DOCUMENT RESUME

ED 311 663 EC 221 079

AUTHOR Haltom, Carl M.; Dillon, Edward J.
TITLE Compendium of General Guidelines for the Development of Programs of Special Education and Related Services for Children and Youth with Handicapping Conditions.
INSTITUTION Delaware State Dept. of Public Instruction, Dover. Exceptional Children/Special Programs Div.
REPORT NO 95-01/80/10/07
PUB DATE 80
NOTE 194p.
PUB TYPE Guides - Non-Classroom Use (055) -- Reports - Descriptive (141)

EDRS PRICE MF01/PC08 Plus Postage.
DESCRIPTORS *Ancillary School Services; Delivery Systems; *Disabilities; Educational Diagnosis; Elementary Secondary Education; Handicap Identification; *Inservice Teacher Education; Preschool Education; *Program Development; Program Implementation; *Special Education; *State Standards; Student Placement
IDENTIFIERS *Delaware

ABSTRACT

These guidelines address the development and implementation of sound, cost-effective programs of special education, related services, and in-service staff development in Delaware schools. The goals of the guidelines are to provide a stimulus for the state-wide development of: (1) realistic and precise individualized education programs (IEPs) for all severity levels of handicaps; (2) a full continuum of on-site programs able to deliver effectively and flexibly the special education and related services required by IEPs; and (3) a manpower development system which fosters dynamic professional growth. The handicapping conditions covered include: learning disabilities, physical impairments, mental retardation, speech and language deficits, hearing impairments, specific visual impairments, deaf-blind impairments, social/emotional maladjustments, autism, and mild handicapping conditions (ages 4 to 6). A common format for discussion of each handicapping condition was established, as follows: nature of the exceptionality; the educational challenge; bases for placement in mainstream or specialized settings; the delivery of special education and related services (identification and diagnosis, the Individual Education Program, and program structure); staff professional growth (focusing on specialized interdisciplinary systems such as special schools and institutional settings as well as a mainstream continuum of services including regular classes, resource rooms, and special classes); references; and glossary. (JDD)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

☑ This document has been reproduced as received from the person or organization originating it

☐ Minor changes have been made to improve reproduction quality

- Points of view or opinions stated in this document do not necessarily represent official OERI position or policy

STATE BOARD OF EDUCATION
DOVER, DELAWARE

ED311663

Compendium of General Guidelines for the Development of Programs of Special Education and Related Services for Children and Youth with Handicapping Conditions

Coordinated by:

Carl M. Haltom, State Director
Exceptional Children/Special Programs Division

Edward J. Dillon, State Supervisor
Exceptional Children's Programs

The Delaware Department of Public Instruction

William B. Keene, *State Superintendent*
John J. Ryan, *Acting Deputy State Superintendent*
Assistant State Superintendent
Administrative Services Branch
Randall L. Broyles, *Assistant State Superintendent*
Instructional Services Branch

EC221079

BEST COPY AVAILABLE

The State of Delaware is an equal opportunity employer and does not discriminate or deny services on the basis of race, color, national origin, sex, handicap, and/or age.

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY

J L
Spartz

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

Delaware State Board of Education

Albert H. Jones
Christiana
President

Richard M. Farmer
New Castle
Vice-president

Robert W. Allen
Seaford

Harry F. Camper
Dover

Elise Grossman
Wilmington

Kenneth V. Hilton
Marabou Meadows

Raymond E. Tomasetti
Claymont

William B. Keene
Secretary

Officers of the Department of Public Instruction

Townsend Building
P. O. Box 1402
Dover, Delaware 19901

William B. Keene, State Superintendent
John J. Ryan, Acting Deputy State Superintendent and
Assistant State Superintendent
Administrative Services Branch
Randall L. Broyles, Assistant State Superintendent
Instructional Services Branch
Howard E. Row, Assistant State Superintendent
Auxiliary Services Branch

CONTENTS

Introduction

Guidelines:

I. **Learning Disabilities**
Guidelines Task Force Chairperson:
Edward J. Dillon, Ed.D., State Supervisor, Exceptional Children Programs, State Department of Public Instruction

II. **Physical Impairments**
Guidelines Task Force Chairperson:
Edward J. Dillon, Ed.D., State Supervisor, Exceptional Children Programs, State Department of Public Instruction

III. **Mental Retardation**
Guidelines Task Force Chairperson:
Barbara E. Humphreys, State Specialist, Exceptional Children Programs, Diagnostician, State Department of Public Instruction

IV. **Speech and Language Deficits**
Guidelines Task Force Chairperson:
Dolores M. Pittelli, State Specialist, Delaware Direction Service Center, Department of Public Instruction

V. **Hearing Impairments**
Guidelines Task Force Chairperson:
Helen M. Holleger, State Supervisor, Early Childhood and Primary Education, Department of Public Instruction

VI. **Specific Visual Impairments**
Guidelines Task Force Chairperson:
Richard L. Connell, State Supervisor, Exceptional Children Programs, Department of Public Instruction

VII. **Deaf-Blind Impairments**
Guidelines Task Force Chairperson:
Richard L. Connell, State Supervisor, Exceptional Children Programs, Department of Public Instruction

VIII. **Social/Emotional Maladjustments**
Guidelines Task Force Chairperson:
Steven Godowsky, State Supervisor, Exceptional Children Programs, Department of Public Instruction

IX. **Autism**
Guidelines Task Force Chairperson:
Steven Godowsky, State Supervisor, Exceptional Children Programs, Department of Public Instruction

X. **Mild Handicapping Conditions (Four to Six Years of Age)**
Guidelines Task Force Chairperson:
Barbara E. Humphreys, State Specialist, Exceptional Children Programs, Diagnostician, Department of Public Instruction

INTRODUCTION

A number of dynamic factors have contributed during the past decade to the need for the present *State of Delaware Compendium of General Guidelines for the Development of Programs of Special Education and Related Services for Children and Youth with Handicapping Conditions*:

- Knowledge has expanded dramatically concerning the specific nature of various handicapping conditions
- Awareness has increased concerning the multiple nature and interrelatedness of handicapping conditions commonly found among children whose problems are moderate to severe in complexity.
- Evidence has accumulated concerning the need for IEPs (Individualized Education Programs) to specify precisely the special education and related services which will be decisive in the habilitation/compensation of each child, especially the multiply handicapped.
- Recognition has deepened concerning the critical importance of realistic and continuous in-service training in all areas and levels of special education and related services.
- Compliance with the provisions of the Education of All Handicapped Children Act of 1975 (P.L. 94-142) has become a national imperative.

The *Guidelines* provide an immediate broad source of current professional information tailored to the needs and interests of practitioners, parents, and members of the community at large concerned with the development and implementation of sound, cost-effective programs of special education, related services, and in-service staff development in the schools.

To cover the full spectrum of handicaps, a general guideline was prepared for each of the major handicapping conditions, as follows:

- Learning Disabilities
- Physical Impairments
- Mental Retardation
- Speech and Language Deficits
- Hearing Impairments
- Specific Visual Impairments
- Deaf-Blind Impairments
- Social/Emotional Maladjustments
- Autism
- Mild Handicapping Conditions (Ages 4 to 6)

To ensure authority and relevance in the field, each *Guideline* was developed by an interdisciplinary, interagency leadership team whose members were selected for their expertise as practitioners in the particular area of services. Designated chairpersons from the Exceptional Children/Special Programs Division, State Department of Public Instruction, provided coordination for each team. In the final stage, drafts prepared by each team were reviewed in-depth by the staff of the Exceptional Children/Special Programs Division. The drafts were then returned to the respective preparation teams for final review and amendments.

Ease of reference and readability of the Compendium was fostered by the establishment of a common format for each of the Guidelines, as follows:

Section I. Nature of the Exceptionality

Section II. The Educational Challenge

Section III. Bases for Placement

- A. Specialized Interdisciplinary Systems — State-wide/Regional Special Schools and Facilities, Intensive Learning Centers, Institutional Settings
- B. Mainstream Continuum of Services (With Multidisciplinary Support) — Regular Classes, Resource Rooms, Special Class Settings

Section IV. The Delivery of Special Education and Related Services

- A. Identification and Diagnosis
- B. The Individual Education Program (IEP)
- C. Program Structure
  - 1. Specialized Interdisciplinary Systems — Statewide/Regional Special Schools and Facilities, Intensive Learning Centers, Institutional Settings
    - a. Leadership
    - b. Facility Spaces
    - c. Staff Composition
    - d. Program Components
    - e. Program Coordination
  - 2. Mainstream Continuum of Services (With Multidisciplinary Support) — Regular Classes, Resource Rooms, Special Class Settings

Section V. Staff Professional Growth

- A. Specialized Interdisciplinary Systems — State-wide/Regional Special Schools and Facilities, Intensive Learning Centers, Institutional Settings
  - 1. General Program Orientations
  - 2. Specific Program Implementations
  - 3. Topical Presentations
  - 4. Model Studies of Individual Children and Youth
  - 5. Professional Practica
  - 6. Product Workshops
- B. Mainstream Continuum of Services (With Multidisciplinary Support) — Regular Classes, Resource Rooms, Special Class Settings
  - 1. General Program Orientations
  - 2. Specific Program Implementations
  - 3. Topical Professional Presentations

Section VI. References

Section VII. Glossary

In the main, adherence to this framework was sustained by the leadership teams.

Because of its penetrating practical approach and applicability, it is anticipated that the Compendium will provide a stimulus for the state-wide development of:

- realistic and precise individualized education programs (IEPs) for all the severity levels of handicaps, including those manifest by the significant numbers of children and youth with two or more major handicapping conditions;
- a full continuum of on-site programs able to deliver effectively and flexibly the special education and related services required by individualized education programs (IEPs) ;
- a manpower development system which fosters dynamic professional growth in every area of special education and related services.

Finally, appreciation is expressed to the many administrators and staff members of the Department of Public Instruction, the Department of Health and Social Services, the Division for the Visually Impaired, the Delaware Learning Center, the Delaware Curative Workshop, and the local education agencies whose leadership, support, and participation made it possible to complete this task. Specific draft team contributors, including consultants, are cited for each Guideline.

Carl M Haltom

Carl M. Haltom, State Director
Exceptional Children/Special
Programs Division

Edward J. Dillon

Edward J. Dillon, State Supervisor
Exceptional Children's Program

STATE OF DELAWARE
GENERAL GUIDELINES FOR THE DEVELOPMENT OF PROGRAMS OF SPECIAL EDUCATION AND RELATED SERVICES FOR CHILDREN AND YOUTH WITH LEARNING DISABILITIES

The Delaware Department of Public Instruction

William B. Keene, *State Superintendent*
John J. Ryan, *Acting Deputy State Superintendent*
Assistant State Superintendent
Administrative Services Branch
Randall L. Broyles, *Assistant State Superintendent*
Instructional Services Branch

STATE OF DELAWARE
GENERAL GUIDELINES FOR THE DEVELOPMENT OF PROGRAMS OF SPECIAL EDUCATION AND RELATED SERVICES FOR CHILDREN AND YOUTH WITH LEARNING DISABILITIES

The Delaware Department of Public Instruction

William B. Keene, *State Superintendent*
John J. Ryan, *Acting Deputy State Superintendent*
Assistant State Superintendent
Administrative Services Branch
Randall L. Broyles, *Assistant State Superintendent*
Instructional Services Branch

The State of Delaware is an equal opportunity employer and does not discriminate or deny services on the basis of race, color, national origin, sex, handicap, and/or age.

Guideline Contributors:

*Edward J. Dillon, Ed.D., State Supervisor, Exceptional Children Programs, State Department of Public Instruction (Guidelines Task Force Chairperson)

Sandra Chin, Learning Disabilities Teacher, Intensive Learning Center, New Castle County School District

John Corradin, Learning Disabilities Teacher, Intensive Learning Center, New Castle County School District

Tina Eisenhower, Learning Disabilities Teacher, Intensive Learning Center, New Castle County School District

*Arlene C. Finocchiaro, Occupational Therapist, The Learning Center, Delaware State Association for Children With Learning Disabilities

*Sandra M. Flowers, Occupational Therapist, The Learning Center, Delaware State Association for Children With Learning Disabilities

Linda Fruit, Occupational Therapist, Delaware Curative Workshop, Inc.

*Virginia L. Glover, Learning Disabilities Teacher, Capital School District

Steven Godowsky, State Supervisor, Exceptional Children Programs (Special Schools)

Mary Ellen Jornlin, Occupational Therapist, Intensive Learning Center, New Castle County School District

Rose Lambert, Learning Disabilities Teacher, Intensive Learning Center, New Castle County School District

*Patricia C. Miceli, Speech Pathologist, The Learning Center, Delaware State Association for Children With Learning Disabilities

Margaret S. Moore, Occupational Therapist, Delaware Curative Workshop, Inc.

*Betty Penrod, Supervisor of Reading, Diagnostic Reading Center, Capital School District

Dolores Pittelli, State Specialist, Direction Service Center, Department of Public Instruction

Maureen Daly Ringstrom, Language Therapist, Intensive Learning Center, New Castle County School District

Kimberly Siegle, Learning Disabilities Teacher, Intensive Learning Center, New Castle County School District

Edward Turnberger, Director, Intensive Learning Center, New Castle County School District

*Betty L. Warren, SEM Teacher and Director of Childfind, Capital School District

* *Core Draft Team*

DEFINITION:

Learning Disability — The child exhibits a disorder in one or more of the basic psychological processes involved in understanding or in using language, spoken or written, which may manifest itself in an imperfect ability to listen, think, speak, read, write or spell, or to do mathematical calculations. The term includes such conditions as perceptual handicaps, brain injury, minimal brain dysfunction, dyslexia, and developmental aphasia. The term does not include children who have learning problems which are primarily the result of visual, hearing, or physical handicaps, of mental retardation, of emotional disturbance, or of environmental, cultural, or economic disadvantage.

(From Section III, G. 5. of the Delaware *Administrative Manual For Programs for Exceptional Children.*)

SECTION I. NATURE OF THE EXCEPTIONALITY

No educational concept is more elusive than the essential nature of learning disabilities. The reason for this is that the symptoms are incredibly subtle and varied in their scope, on-set, and dynamics. If the true nature of the handicap is to be made clear, full consideration must be given to all aspects.

The Critical Issue

Fortunately, the complexity of a learning disability reduces to a single critical issue for each exceptional child or youth—are his/her abilities to acquire, apply, and communicate information as efficient (mature) as they should be? Such abilities may be referred to as the information processes. Through their development the child learns how to learn.

Development of the Information Processes

The information processing abilities develop, in general, along two successive, coordinate levels (a basic level and a higher level). Competencies on the basic level develop from birth. By seven years of age for most children, these abilities (including the sensory-motor, perceptual, and the basic receptive and expressive language processes) will be sufficiently mature to meet the initial mastery demands of the primary academic curriculum (essentially, the foundation skills and cognitive abilities of the higher level information processes—reading, writing, computation, etc.).

For a given child, if there have been significant delays/interruptions in his/her early childhood development, the expectation of satisfactory school achievement will be guarded. It is recognized that many otherwise normal children for various reasons may not achieve full readiness for school until eight years of age. To meet their needs, a progressive differentiation in the general curriculum is essential. The immaturities of the child with a specific learning disability, however, are more profound and unique in nature. Their instruction must be based on an individualized education program. The discussion which follows provides a concise orientation to the development of the information processing abilities and their educational significance, especially for children with specific learning disabilities.

From a dynamic perspective, the information processes develop through the progressive integration of all the modalities and functions—the basic level and the higher level.

On the basic level, concrete sensory information concerning the body comes immediately from any physical activity. This continuous internal feedback (proprioceptive and vestibular) is essential to the coordination of all postures and movement. Simultaneously, touch, taste, smell, hearing, and vision provide preceptual information concerning the environment as well as the self. The two dimensions of concrete information (internal and external) are integrated from moment to moment in all respects to unify the experience of the physical world.

Such integration, in turn, perfects the efficiency of the sensory-motor processes. Gross and fine motor activities become more precise, flexible, and anticipatory. Perceptual processes become more aware and discriminating, and better organized. The processes of visual and auditory perception, in particular, begin to acquire the ability to provide vicarious experiences. In this respect, children learn to anticipate by vision or hearing alone the experience of touch associated with the handling of familiar objects. Secondarily, visual and/or auditory imagery may be evoked through touch alone.

From the larger perspective of the development of the whole child, the dynamic relationship between sensory-motor integration and language acquisition is of critical importance. The processes of basic receptive and expressive language develop simultaneously and in continuous linkage with direct sensory experiences. An immediate, flexible integration is established gradually between these two worlds—the symbolic and the concrete. Language becomes the stimulus for behavior and the means of communicating simple needs and experiences.

On still another level, the integrations of language stabilize and intensify cognitive organization. Perceptions of the moment are synthesized in patterns (percepts). Concepts are abstracted from the percept patterns, organizing the mind in ever expanding vistas of understanding. In time, the progressive developmental integration of language and cognition establishes vicarious experience as the primary source of information and intellectual growth. Children become good listeners, for example, when they have learned to "see" in their own mind information presented through hearing alone. Because of their perceptual development, good listeners usually learn to be good readers, except that the information of reading is presented in the visual code of printed symbols.

On the higher level, the demands of the school require all of the language arts (reading and writing, as well as the basic competencies of listening and speaking) and the graphic and quantitative processes. These higher abilities must be integrated with those on the basic level, and they must be integrated with each other. By school age, the readiness to achieve the higher abilities and accomplish their total integration should be well established. The kindergarten child who can effortlessly coordinate his postures and movements, maintain sensitive awareness of the world about him (especially through the full potentialities of vision and hearing), and use language simultaneously to listen to the experiences of others and communicate his own, will be well on his way to success in school.

The Origin of Learning Disabilities

A learning disability occurs when the above described integrations, essential to the efficient acquisition of information, become deficient/distorted in whole or in part on any level of development due to processing dysfunctions specifically within the child and not simply to deprivations in his/her experience or to personal/social maladjustment. Among the basic level abilities, such integrative dysfunctions are usually manifest early in life (typically from 12 to 36 months of age). As the manifestations are compounded in the course of development, the problems become more severe — more comprehensive. Such disabilities lead invariably to disabilities on the higher level. Eventually, all of the levels and areas of information processing (the sensory-motor, perceptual, language, personal-social, and the academic) may become involved.

In contrast, some disabilities are unique to the higher level information processes. For example:

- dyslexia — the total or partial inability to perceive letters/words;
- dysgraphia — the total or partial inability to write and/or spell;
- dyscalculia — the total or partial inability to make mathematical calculations.

Such problems may not be observable until the primary school years. They may occur in combination. Fortunately, they are of relatively low incidence.

Some Implications for Education

Practical implications of the above discussion can be seen immediately in the area of reading problems. Ordinarily, professional practice determines a reading problem to exist for a given child when his/her level of achievement in basic reading skills falls significantly below his/her level of learning aptitude (expected reading achievement).

However, in the case of an early progressive learning disability involving the basic level abilities, pupil performance will be poor on measures of aptitude as well as achievement. In these instances, the habilitation of the disability has been observed initially to improve performance on assessments of learning aptitude. Thereafter, through an effective remedial reading intervention, reading skills have been shown to advance to instructional levels commensurate with the improved aptitude for learning. For these children, habilitation of the basic level abilities facilitated remediation of the higher level skills.

Accordingly, errors in diagnosis will result when exclusive emphasis is placed on discrepancies between aptitude and achievement as the only criteria for the identification of a learning disability. During early childhood and the preschool and primary school years, such discrepancies are frequently minimal or non-existent among the truly learning disabled. In these cases, as indicated above, successful child interventions in Delaware have documented that the initial clinical intervention should seek to improve the abilities to learn. Secondarily, the intervention should seek to remediate specific school readiness and academic skills to levels of achievement (competence) commensurate with the child's newly improved aptitude to learn. In simplest terms, the intervention should create a discrepancy and then close it.

In the case of a unique higher level disability (such as dyslexia, dysgraphic or dyscalculia), the relationship of achievement to aptitude will resemble that of a typical remedial reading case. From the beginning of the intervention, aptitude measures will tend to indicate a relatively promising potential for learning, but skills achievement will lag. However, in contrast to a clear-cut reading problem, the prognosis for a unique higher level disability will be much more guarded in that the remediation of certain skill deficiencies may demand the most intensive efforts and expertise applied individually.

In general, a learning disability may result in a complex reading problem. However, the existence of a reading problem does not, of itself, indicate the presence of a learning disability. In most instances, the typical mild to moderate reading problem is due to any number of other personal, social, and school related causes. *Too often, the* *label of learning disability is applied indiscriminately to any child who may not be performing well in school.* Ambiguities in the current definitions of a specific learning disability and a corrective reading problem tend to magnify these diagnostic errors.

It is of the utmost importance, therefore, that there be a sensitive, authoritative diagnosis of any potential learning disability. A lack of discipline and thoroughness in this responsibility can misdirect the development of the individualized education program (IEP). Given enough incidences, these individual misdirections can disorganize a total program, including regular as well as special education.

Manifestations — A Closer Look

Among the learning disabled, the massive developmental arrests found among the physically impaired and severely-profoundly multiply handicapped will not be in evidence. ***Even in the case of a progressive, comprehensive learning disability, development will continue.*** However, inconsistent, erratic behavior and performances will be characteristic due to subtle immaturities and distortions in the full achievement of normal age-level competencies. In this respect, at the lower processing levels, the inability to achieve and maintain normal levels of sensory stimulation and awareness will be particularly evident in experiences of touch, hearing, and vision. Difficulties will also occur in attending purposefully and flexibly to key stimuli in the environment and in discriminating and integrating such stimuli into clear images, meanings, and memories. On the motor side, difficulty in interpreting and integrating feedback information concerning balance, touch, and movement causes subtle, but significant inefficiences in postural control and locomotion and in the finer skills of manual dexterity and eye movement. In addition, the patterns of movement will be poorly synchronized and coordinated.

Immaturities in receptive and expressive language may parallel dysfunctions in the sensory and motor areas. Typically, the listening abilities of the child or youth with a learning disability will be capable of grasping the more concrete meanings, but incapable of understanding precisely crucial essentials and details. Speech communication may appear to be appropriate; however, the content will tend to be superficial and irrelevant.

The coordination of language with sensory experiences and motor behavior will also be poorly developed. The ability to listen to directions and to carry them out will be difficult. Similarly, the ability to tell of past, present, and anticipated activities will be limited. Immaturity in the matching of language to pictures is often seen. In the cognitive area, immaturity can be demonstrated in the development of the ability to make consistently accurate perceptual judgements. The child may misjudge the order, number, length, amount, area, or weight of objects when their arrangement or presentation is modified, even though it is clearly indicated to the child that no other change has taken place.

The learning disabled child or youth will often be able to compensate and/or conceal such dysfunctions in whole, or in part, through the labor of over managing his/her way through the ordinary daily activities which should be coordinated with the ease and facility of routine. In general, these total efforts will be fatiguing and inefficient, tending to "break down" under marginal increases in normal stress levels. To the brief observer, the learning disabled child may appear to be normal. At best, however, such apparent normality will be distressingly fleeting and inconsistent. Maximum efforts cannot be sustained indefinitely by normal adults let alone by children manifesting psycho-neurological inefficiencies.

Manifestations — A Broader Look

The problem of learning disability may occur in its own right (specific learning disability) or in association with any other handicapping conditions (associated learning disability). In the latter respect the information processing dysfunction will be exaggerated or abated depending on the nature and severity of the related handicapping condition(s). Among the severely mentally handicapped and the physically impaired, for example, dysfunctions in processing information will be profound. Among the educable mentally handicapped, such dysfunctions will be more akin to those characteristic of a specific learning disability.

Concerning all of the preceding discussion, there are indications that some children with significant symptoms of information processing dysfunctions are able to cope or compensate successfully with such problems without the benefit of special services.

Others require special help if they are to improve. Although it is reasonable to assume that only the milder cases will respond successfully on their own, there is, nonetheless, the need for systematic study in this area.

It must also be anticipated that traumatic accidents may occur at any point in development. The sequelae of such traumas may unfold in unpredictable patterns of learning disability.

Finally, the frustrations and conflicts attending a learning disability in the personal-social area may lead to a chronic overlay of maladjustment. Frequently, the behavioral overlay is misjudged as the core problem — as in the case of a significant number of youth categorized as delinquent. More often, especially in childhood, the learning disabled will reflect an absence of zest and vitality. For some, however, behavior will exhibit the driven qualities of inconsistency, distractibility, impulsivity, perseveration, hyperactivity, and irritability. The patterns of manifestations from individual to individual and from age to age within each individual will vary significantly. In all such instances, the child or youth will experience in some degree the sense of inadequacy associated with a self-image which anticipates failure. From the educational standpoint, the primary emphasis in programming should center on the habilitation and/or compensation of the basic information processing abilities.

SECTION II. THE EDUCATIONAL CHALLENGE

The scope of the educational challenge in meeting the needs of the learning disabled is extraordinary. Such dysfunctions are subtle and pervasive. They may occur as specific learning disabilities; they may occur in association with other handicapping conditions; or they may be manifest in their mildest form among children or youth who would not ordinarily be thought of as handicapped.

Wherever possible, identification and habilitation should be initiated at the early childhood level and pursued systematically as long as necessary. Such initial intervention is still feasible during the academic years, but the possibility of optimal habilitation will be greatly diminished. In any instance, individual education programs for the learning disabled, if they are to be effective, must emphasize habilitation and/or compensation of the specific, critical dysfunctions in the information processes.

Considering all of the individual variables of severity, complexity, and chronological age at the time of intervention as well as the various supportive and adverse factors in the delivery of services, it must be conceded that the professional knowledge base with respect to this handicapping condition is very uneven. Accordingly, discussion of the educational challenge in this area will emphasize early childhood intervention in learning disabilities which are specific—a focus based on documented programs and case studies in Delaware. A sequence of four intervention levels in the basic information processes will be considered: *early developmental habilitation, extended developmental readiness, developmental academic support, and vocational adaptation*. The discussions follow:

Early Developmental Habilitation—
Wherever possible for manifestations of learning disabilities at the earliest levels (birth to 36 months of age), there should be intensive diagnosis and habilitation at least by the preschool and kindergarten levels. Many excellent programs at the infant and early childhood levels are demonstrating conclusively the importance of such early developmental intervention. Although there is relatively less program experience in intensive habilitative intervention at the middle and high school levels, successful experimental interventions in individual instances indicate clearly the need for expanded program services for the older student.

In any respect, professional intervention services for *early developmental habilitation* are highly specialized and require an intensive systematic interdisciplinary team which should be able to provide, as necessary, all of the therapies (physical, occupational, and speech/language), as well as special educational assessment, evaluation, and corrective and remedial reading. The therapeutic intervention team should have special knowledge in the area of learning disabilities, and it should have unified program supervision as well as appropriate medical supervision.

The content of early developmental habilitation should emphasize improvement of the abilities to:

- maintain functional awareness of the body, its parts and what they can do, such as knowing where one is touched or knowing what direction one's limbs are being moved;

- match the intensity of behavioral output with the level of sensory input, as seen in overreaction or underreaction to stimuli, such as aggressive movement following a light tap, or conversely, not feeling a light tap to the shoulder;
- maintain consistent responses to repetitious or prolonged tasks;
- sustain the equilibrium and efficiency of head and trunk control essential to prolonged sitting, standing, and arm-hand movement;
- utilize a preferred hand consistently as the lead hand in manipulative and graphic activities;
- maintain steadiness and efficiency of fine movement in activities such as handwriting and graphics;
- sustain balance for tasks which require body shifting such as rolling, sitting, crawling, walking etc.;
- formulate an efficient plan of action to carry out a task;
- sense immediately survival information, such as withdrawal from noxious odors, recognition of pain, avoidance of environmental hazards, etc.;
- sort out the important or pertinent auditory/visual stimuli from other sounds and sights in the environment;
- discriminate whether two sensory inputs are alike or different;
- perceive meaning from the environment;
- attend to and gain meaning from multiple stimuli simultaneously, such as oral reading or listening to teacher's directions while visually attending to a diagram;
- perceive the interrelationships of the body and objects in space and time, including interrelationships of components and dimensions within objects (form perception);
- sequence stimuli in a prescribed order;
- provide for short-term and/or long-term storage and recall of information;
- assimilate and organize experiences internally through the influence of inner language structure, but without the explicit use of language symbols;
- understand spoken words, sentences or a body of information of age-appropriate conceptual/grammatical complexity;
- generate grammatically correct and meaningful sentences to convey information.

Extended Developmental Readiness —
At this developmental level the areas of program intervention are related, in general, to those described for *early developmental habilitation*. However, the dysfunctions encountered at this stage will be milder in immaturity; that is, generally not less than approximately 30 months of developmental age. Because of their milder manifestations, these problems can be met by a teacher with a developmental background working with a small group. Specific consultation should be available, as needed, from an interdisciplinary resource team.

If such programs are to be optimally effective, a high level of structure is necessary in profiling the specific needs and areas of progress and lag for each child. Program materials must be well referenced to the levels of developmental need for each individual. Excellent models now exist to show the implementation of such highly structured developmental programs at the preschool, the kindergarten, and extended readiness sections of the primary school levels.

This type of program also has great significance for the mainstream since it requires the differentiation of programming from level to level through all twelve school years to be truly responsive to the normal developmental differences in children. Once again, there are models of such an effort in progress. The benefits to individual children in terms of the elimination of the school failure syndrome appear to far outweigh the difficulties of program realignment. Such programs can be of benefit not only to the learning disabled child, but to many other children with developmental delays who may not need such services on an intensive basis.

Developmental Academic Support —

Program services on this level emphasize the importance of implementing the instructional program in accordance with the developmental maturity or readiness of each individual. The program itself must be highly structured through all instructional activities to ensure successful experiences on the part of the child. Within such a program, the pace of instruction proceeds according to the learning speed of the student. The child with a learning disability usually needs more time than the mainstream provides to master the basic skill and content areas. In this respect, for the learning disabled child there should be:

- an emphasis on experiences that directly involve concrete materials;
- instruction centered on a limited number of skills;
- emphasis placed on writing and discussion as well as reading instruction;
- program flexibility with activities changed frequently to maintain interest and attention;
- provision of materials specifically as needed for a particular instructional activity;
- graphic outline or intensification of visual materials as necessary to focus attention;
- explanations given in any activity for particular equipment or materials;
- well defined purposes for any instructional activity;
- thorough instruction through each activity, including varied yet closely related presentations and activities to develop specific skills and information;
- frequent opportunities provided for pupil explanation and participation;
- varied instructional practice periods and provision for independent work periods;
- a structured environment for learning which minimizes distractability and fosters a sense of pupil control and security;
- provision for frequent review and evaluation of work in progress.

Above all, such children must be taught on their appropriate instructional or challenge levels according to well-established procedures and methods for teaching in all skill areas. As necessary, appropriate multi-sensory methods should be applied for individuals, such as the visual, auditory, kinesthetic, and tactile word learning approaches (VAKT). Language experience programs and linguistic and programmed materials should be emphasized for their simpler structure in the presentation of instructional tasks. Disciplined, yet flexibly arranged, directed reading-thinking activities are of critical importance to the development of comprehension and word recognition skills. In the quantitative area, structured manipulative and graphic materials should be utilized to focus attention and to link the abstract quantitative processes to concrete reality.

In perspective, the discussion above of principles pertaining to *developmental academic support* is applicable, more or less, to the education of all children. For the child or youth with a learning disability, the application of such principles must be extremely well structured and flexibly adapted to the unique instructional needs of the individual.

Vocational Adaptation—

Beginning at the middle school level when prevocational training is introduced into the school curriculum, the learning disabled child should be given full consideration for participation in the program. All of the principles and emphases of *developmental academic support* apply to the implementation of the vocational education programs for children or youth with learning disabilities. In addition, as indicated, emphasis should be given, at least initially, to concrete, manipulative experiences which afford maximum opportunities for elaborative "hands on" types of experiences, such as in horticultural programs, woodworking, electronics, photography, amateur radio, etc. Beyond such foundation, the direction and level of vocational education must be adapted to the unique needs and potential of each individual.

It is essential that the individualized education program (IEP) at this level and beyond bring together the educational and therapy specialists, as well as the coordinative representatives of vocational training programs to ensure that appropriate services in this area are available for each child or youth.

The Implications for Implementation—

For a child or youth with a learning disability, depending on his/her age and the nature of the problem, one or more of the above intervention levels may be appropriate at a particular stage. For the very young child, the mode of intervention will necessarily be that of *early developmental habilitation*. For the older child with a learning disability in the primary school years, several modes of intervention may be essential *(early developmental habilitation, extended developmental readiness and developmental academic support)*. The component of *early developmental habilitation* might be provided by the individual follow-up and consultation of an interdisciplinary team. *Extended developmental readiness* could be provided through an extended readiness class and/or adapted physical education program. *Developmental academic support* could be implemented through differentiated grouping in the mainstream, or in a special education setting. The challenge to education is to develop the cost-effective service delivery systems which ensure that these intervention resources are available wherever and whenever they are required by the IEP of a particular child or youth. *Finally, successful intervention for the child or youth with a learning disability, whether specific or associated, depends in large measure on effective, on-going involvement of the parents or primary care-givers in the development and implementation of the individualized education program.*

SECTION III. BASES FOR PLACEMENT

A. *Specialized Interdisciplinary Systems — State-wide/Regional Special Schools and Facilities, Intensive Learning Centers, Institutional Settings*

Placement in a specialized interdisciplinary service system is essential when the complexity and intensity of the learning disability requires a total closely coordinated day-to-day intervention by a specialized interdisciplinary team with the in-depth expertise and specific commitment to the habilitation and/or compensation of such disabilities. Interventions in such settings will usually emphasize early developmental habilitation with provision, as necessary, for extended developmental readiness and developmental academic support. In most instances, appropriate placement for the child or youth with a moderate to severe specific learning disability will be in an intensive learning center with the specialized expertise and integrated service system essential to programming effectively for such disabilities.

B. *Mainstream Continuum of Services (with Multidisciplinary Support) — Regular Classes, Resource Rooms, Special Class Settings*

Placement in the mainstream continuum is usually appropriate for the child with a milder learning disability. The intervention components available in such settings typically include: extended developmental readiness, developmental academic support, and vocational adaptation.

SECTION IV. THE DELIVERY OF SPECIAL EDUCATION AND RELATED SERVICES

A. *Identification and Diagnosis*

Because of the importance of establishing from the outset a sound direction for the individual intervention, the initial identification and diagnosis of a specific learning disability should be determined on the basis of an adequate assessment of all pertinent medical, clinical (speech/language, audiological, etc.), and developmental factors, and a summative profile showing the relative strengths and weaknesses of the child or youth in the full range of developmental-educational competencies. Such information provides the basis for the development of the individualized education program.

B. *The Individualized Education Program (IEP)*

For a child or youth with a specific learning disability, the development and application of an individualized education program (IEP), including special education and related services, is the professional responsibility of an interdisciplinary team with appropriate expertise in the area of learning disabilities. In a specialized interdisciplinary system such responsibility is an administrative responsibility and accountability of the principal or coordinator of the intensive learning center or program for the learning disabled. In the mainstream continuum such accountability is a responsibility of the regular building principal working in accordance with state regulations and guidelines.

C. *Program Structure*

1. *Specialized Interdisciplinary Systems—State-wide/Regional Special Schools and Facilities, Intensive Learning Centers, Institutional Settings*

a. *Leadership*

Because of the subtle complexity of the developmental-educational problems encountered in the area of learning disabilities, it is essential that each special school or consortium facility in this area be supervised directly by a qualified administrator or coordinator with specific expertise in this area or full awareness of the nature of learning disabilities and expert consultative backup.

b. *Facility Spaces*

Each intensive learning center or facility for the learning disabled should include:

- instructional areas;
- administrative spaces;
- access to therapy areas (including physical and occupational therapy and speech/language spaces);
- access to physical education areas (including adaptive physical education spaces);
- access to health center;
- access to prevocational training area (shops, home arts components, etc.).

c. *Staff Composition*

Provision must be made, as appropriate, for an adequate level of services in each of the following areas:

- special education (teachers for the learning disabled);
- physical and occupational therapy (therapists, aides, and physical education teachers);
- speech/language development (therapists, teachers, and aides);
- reading/developmental-reading (specialists);
- psychological services (especially with expertise in child and adolescent development and behavioral management);
- psycho-educational evaluation;
- prevocational education (teachers).

Provision for social work, guidance, library administration, art and music instruction, school psychology, and physical education will be determined and recommended by the principal or coordinator in charge of the program based on his/her analysis of the actual needs of the assigned pupil population.

d. *Program Components*

The full service facility for the learning disabled will provide a total program in the following areas:

early developmental habilitation;
extended developmental readiness
developmental academic support
vocational adaptation.

From the child's standpoint, a full range of habilitative and compensatory training activities should be available (with initial emphasis on the developmental masteries from 12 through 36 months) in the areas of postural equilibrium and locomotion, manual dexterity and haptic awareness and oral-motor competence, language acquisition and the personal and social competencies of the learner. At the appropriate times, graphics, mathematics, the language arts and adaptations of the regular content areas will be incorporated in the program.

To intensify the effectiveness of all program implementations, there must be adequate provision for systematic behavioral management for individuals and for groups. This dimension of programming is an essential supportive component to the curriculum goals for each child or youth.

e. *Program Coordination*

Special education and related services for the learning disabled in a total service setting must be provided through a well supervised, interdisciplinary team approach in which each discipline has an obligation to contribute to the systematic development and implementation of the individualized education program (IEP). The team must have specific expertise in the area of learning disabilities. Consultative follow-along services may be provided, as necessary, for students mainstreamed from the program.

2. *Mainstream Continuum of Services (with Multidisciplinary Support) — Regular Classes, Resource Rooms, Special Class Settings*

   It is anticipated that the needs of children with the milder types of learning disabilities requiring, in most instances, only extended readiness programming and a supportive academic approach, can be met with appropriate adaptations in the regular classroom, including resource room utilization, as necessary.

SECTION V. STAFF PROFESSIONAL GROWTH

The range of individual differences in the manifestations of learning disabilities from the preschool through the secondary years is extraordinary. Depending on the nature of the child's problem, intervention may be necessary on one or more levels (early developmental habilitation, extended academic readiness, developmental academic support, vocational adaptation). Therefore, a state-wide in-service program must have as one of its primary missions the development of the instructional, coordinative, and administrative expertise and creativity essential to the delivery of effective program services to the individual on any level of intervention.

It cannot be assumed that the preservice preparation of staffs has included the many levels of developmental awareness and technical competence required by an effective intervention program for children or youth with learning disabilities. Accordingly, an in-depth, multi-level in-service program is necessary to meet the many types of training needs which can be anticipated. Such a training program should provide a sound theoretical/professional introduction, including:

- a broad orientation to normal and deviant development, primarily from the standpoint of the emergence of the information processes (the developmental-educational perspective);
- topical orientations to special education and related services from the devlopmental-educational perspective for children and youth with learning disabilities, with critical consideration of such background concepts as—
    —the nature of learning disabilities (specific and associated)
    —organization of the interdisciplinary child study process in education
    —the issue of challenge levels for program implementation
    —developmental task analysis (determining dynamic goals, objectives and activities)
    —guiding the achievement of the generalizations in learning
    —shaping behavior (developing attention and follow-through, motivation and personal and interpersonal adjustment)
    —the developmental interdisciplinary approach to pupil progress evaluation and accountability;
- intensive interdisciplinary professional training in—
    —the assessment process
    —development and evaluation of the individualized education program
    —development and coordination of an effective interdisciplinary service system
    —methodologies and professional role responsibilities.

Beyond the foundations level, advanced in-depth professional presentations and seminars are necessary in the different areas of programming for learning disabilities with respect to the most productive and efficient:

- assessment strategies and psychoeducational technologies;
- approaches to the individualized education program;
- interdisciplinary service delivery systems;

- specific principles and methodologies of special education, remedial education and related services;
- program evaluation and pupil progress accountability.

Finally, as a "backup" to the didactic in-service programs (introductory and advanced), "hands-on" in-service must be provided in the field to directly support sound program implementation state-wide. Such in-service should include:

- provision for visitation by field staffs to model demonstration sites delivering services on every level of program intervention (early developmental habilitation, extended academic readiness, developmental academic support, vocational adaptation);
- model case studies on-site by expert interdisciplinary consultant teams working with the local child study team(s);
- collaborative consultant workshops on-site to determine and recommend appropriate corrective steps with respect to gaps in the delivery of services and the establishment of essential program resources.

The goals of the total state-wide in-service effort are:

- to ensure for all staffs concerned with the problem of learning disabilities (whether specific or associated in nature and whether mild, moderate, or severe in complexity) a broad understanding of the nature of the problem and the implications for education;
- to provide the specific concepts, approaches, methods, and technical assistance for effective intervention wherever the problem may be encountered.

The state-wide training emphasis is necessarily on the development of program and administrative leadership personnel at the local level, including the full spectrum of special education teachers and specialists as well as vocational educators concerned with the development and implementation of programs for children or youth with specific or associated learning disabilities. Participation in state-wide special study institutes of the type indicated above may be on a group or an individual basis as staff needs dictate. Systematic provision for dissemination of the training information locally is encouraged through on-site topical reports, seminars, and case studies conducted by institute participants.

SECTION VI. REFERENCES

Ayres, A. Jean. *Sensory Integration and Learning Disorders.* Western Psychological Press, Los Angeles, c. 1972.

Bender, Miriam L. *The Bender-Purdue Reflex Test and Training Manual.* Academic Therapy Publications, San Rafael, California, 1976.

Brutten, Milton; Sylvia O. Richardson and Charles Mangel. *Something's Wrong With My Child.* Harcourt Brace Jovanovich, New York, 1973.

CADETS—Child Accountable Developmental Education and Teaching Strategy. Dr. Edward J. Dillon, Delaware Department of Public Instruction, et al, 1978.

Coleman, James C. "Life Stress and Maladaptive Behavior," *American Journal of Occupational Therapy,* May-June 1973, Vol. 27, No. 4, 1973, pp. 169-180.

Cushenbery, Donald C. *Reading Improvement Through Diagnosis, Remediation, and Individualized Instruction.* Parker Publishing Co., Inc., West Nyack, New York, 1977.

deQuiros, Julio B. and Orlando Schrager. *Neuropsychological Fundamentals in Learning Disabilities.* Academic Therapy Publications, San Rafael, California, 1978.

Dillon, Edward J.; E. Heath and C. Biggs. *Comprehensive Program for Learning.* Merrill, 1970.

Early, George H. "Learning Disabilities: An Information-Processing Model." *The School Psychology Digest.* Vol. 5, No. 1, Winter, 1976.

Gessell, Arnold. *Vision: Its Development in Infant and Child.* Hafner Publishing Co., Inc., New York, 1967.

Herber, Harold L. *Teaching Reading in Content Areas.* Prentice-Hall, Englewood Cliffs, New Jersey, 1969.

Ilg, Frances L. and Louise Bates Ames. *School Readiness.* Harper and Row, New York, 1965.

Kennedy, Eddie C. *Classroom Approaches to Remedial Reading.* 2nd edition, F. E. Peacock Publishers, Inc., Itasca, Ill., 1977.

Kephart, Newell C. *The Slow Learner in the Classroom.* 2nd edition. Charles E. Merrill Publishing Co., Columbus, Ohio, 1971.

KINDERSTEPS *Structured Development Kindergarten Program.* Milford School District, Milford, Delaware, 1970.

Koppitz, Elizabeth M. *The Visual Aural Digit Span Test.* Grune and Stratton, New York, c. 1977.

McCarthy, James J. and Joan H. McCarthy. *Learning Disabilities.* Allyn and Bacon, Inc., Boston, c. 1969.

Myklebust, Helmer R. *Development and Disorders of Written Language, Vol. I, Picture Story Language Test.* Grune and Stratton, New York, c. 1965.

Myklebust, ed. *Progress in Learning Disabilities, Vol. I,* Grune and Stratton, New York, c. 1968.

Price, Antje; Elnora Gilfoyle and Cordelia Myers. *Research in Sensory Integrative Development.* American Occupational Therapy Association, Rockville, Maryland, 1976.

Reynolds, M. C. and J. W. Birch. *Teaching Exceptional Children in All America's Schools.* Council for Exceptional Children, Reston, Virginia, 1977.

Schnitker, Max. *The Teacher's Guide to the Brain and Learning.* Academic Therapy Publication, San Rafael, California, c. 1972.

Simpson, Dorothy M. *Learning to Learn.* Merrill Publishing Company, Columbus, Ohio, c. 1968.

Strauss, Alfred A. and Laura Lektinen. *Psycho-Pathology and Education of the Brain-Injured Child.* Grune and Stratton, New York, c. 1947.

Tarnopol, Lester and Muriel. *Brain Function and Reading Disabilities.* University Park Press, Baltimore, Maryland, 1977.

U. S. Government. *The Child With Central Nervous System Deficit.* U. S. Department of Health, Education, and Welfare, Washington, D.C., 1965.

Vogel, Susan Ann. *Syntactic Abilities in Normal and Dyslexic Children.* University Park Press, Baltimore, Maryland, c. 1975.

Wiig, Elisabeth H. and Semel, and Eleanor Messing. *Language Disabilities in Children and Adolescents.* Merrill Publishing Co., Columbus, Ohio, 1976.

SECTION VII. GLOSSARY

assessments of learning aptitude. Tests intended to measure an individual's potential for learning certain skills or subjects.

auditory. Pertaining to the system of analyzing and translating language and non-language information taken in by the ears but processed by the brain.

bilateral. Having or involving two sides.

body schema. A conceptualization of the self for a reference point for estimating direction and amount of movement.

closure. Separate parts of a visual or auditory message come together into a meaningful and purposeful concept.

cognitive. Refers to the psychological processes involved in the formation and utilization of symbols and concepts during thinking, reasoning, and problem-solving.

concrete. Characterized by or belonging to the immediate experience of actual things or events.

conservation. A developmental conceptual process by which an aspect of an object is held constant and its properties unchanged in spite of being displaced or moved.

constancy. A developmental process through which the specific attributes of objects (size, form, etc.) are perceptually maintained even though their concrete manifestations shift continuously in an ever changing world.

convergence. To focus on a moving target as it moves toward the person.

critical. A point at which information processes are able to mutually increase each other's response efficiency.

developmental delay. A lag in a child's maturation as compared to age expected behaviors. Discrepancy in performance level and age level. This term does not connote cause of the delay—deprivation, neurological impairment, mental retardation, "late bloomer." Nor does this term suggest potential level of function or outcome of the delay.

developmental dyslexia. Inability to associate printed letters and words with spoken sounds, thus presenting difficulties in reading, written language, spelling. This condition is often considered hereditary.

directional orientation. Extension into the environment of concepts from one's body such as left, right, up, down, front, back, etc.

distractibility. Inability to attend only to pertinent stimuli—easily diverted by impinging stimuli.

divergence. To focus on a moving target as it moves away.

dominance. Consistent preference for one body side in an activity.

dysfunction. Abnormal, incomplete or impaired functioning. Disturbance in the functioning of the information processing system.

equilibrium. The interplay between gravity and body movement allowing for balance and safe postures.

expressive language. Generating words and meaningful/grammatical statements to communicate specific ideas or to elicit specific responses; speaking, writing, and gesturing are expressive language modalities.

figure-ground. Sorting out the focal part of sensory information from the background in which it is presented, such as the teacher's voice from classroom noise or a word on a chalkboard among other words.

graphic. Representation through drawing, writing, painting.

gustatory. The sense of taste.

habilitation. Developing individual skills and abilities which have never been developed. Rehabilitation is redevelopment or relearning of a lost skill or behavior.

haptic awareness. The abilities to discriminate through involvement and touch variations in the configuration, weight, temperature, texture and pressure of objects.

head and trunk control. Developmental differentiation and stabilization of head and body postures and movements independent of body and limb positions.

hyperactivity. Excessive movement due to a tendency to be overly excited by sensory stimuli and poor inhibition of motor output.

immaturities. Delayed developmental functions.

impulsivity. Inclination to act suddenly without forethought.

information. Individual or sequential stimulus events intended to be processed by the learner.

information process or processes. A system or systems for analyzing and translating information into appropriate and purposeful responses.

information processing. Complexly interrelated information processes mutually increasing each other's response efficiency.

inner language. The process of internalizing and organizing experiences without the explicit use of language symbols.

integration. The mental act of combining various kinds of sensory qualities to obtain maximum information about an object or situation.

interdisciplinary team. A group composed of persons from several fields of study which evaluates and delivers appropriate services to the child. Emphasis is on communication of findings and goals in all areas so that all of the child's needs may be served. Team may consist of teacher, nurse, M.D., occupational or physical therapist, speech and language pathologist, parent, etc.

irritability. Excessive response or quick excitability to a mild stimulus.

kinesthesis. The perception of movement, weight, position. The sense of position and movement of the body... Practically, it refers to body information provided by motor activities and movements. (Definition from *Neuropsychological Fundamentals in Learning Disabilities* by deQuiros.)

language acquisition. The abilities to acquire, use and understand patterns of sound, body language, words, and sentences.

language therapy. The professional field which habilitates/remediates dysfunctions in concept development, vocabulary, work meanings, auditory comprehension, sentence formulation, grammar, and the processes which underlie these.

listening ability. Consciously focusing and maintaining attention on what is heard (shutting out background sounds) for the purpose of comprehending.

locomotion. Purposeful movement from place to place in a variety of ways: crawling, creeping, rolling, walking, running, etc. (Flexible equilibrium responses accompany all movement. Such responses are sometimes referred to as dynamic equilibrium.)

maladjustment. Poor adjustment or adaptation to physical or emotional stress.

manual dexterity. Efficient eye-hand coordination in reaching, grasping, manipulating, and releasing objects and in catching and throwing. (A preferred hand is established. The non-preferred hand supports the efficiency of the preferred or lead hand.)

motor behavior. Observable movement and movements.

normal levels of sensory excitation/awareness. An automatic balance between the turning on turning off of sensory information.

object permanence. A developmental conceptual process by which an object does not cease to exist when it disappears and there is awareness of where it has gone.

occupational therapy. Habilitation or rehabilitation of physical perceptual or cognitive disorders through specific goal oriented tasks which are designed to correct or remediate the impairment. Planned and implemented by a registered occupational therapist (OTR).

ocular fixation. Directing both eyes to focus on a point.

olfactory. The sense of smell.

oral-motor competence. Efficient voluntary control of the anatomical structures essential to breathing, eating, and drinking.

perceive. To become aware of through the senses—vision, hearing, taste, touch, smell, temperature, pain, internal chemical responses, and vestibular and proprioceptive sensitivity.

perseveration. Continued performance of the same act even though it would be appropriate to stop performing the act.

personal-social competence. The abilities to care for self and to function with age appropriate maturity in the roles of son/daughter, peer, pupil, employee, citizen, etc.

physical therapy. Habilitation or rehabilitation of physical disorders through specific exercises, neuromuscular facilitation techniques, or hydrotherapy or other physical means. Planned and implemented by a registered physical therapist (RPT).

physically impaired. Bodily handicaps due to structural deformity of the body, disease of muscle or damage to the nervous system.

postural equilibrium. Immediate flexible adaptation to the force of gravity in a variety of postures: lying, sitting, kneeling, squatting, standing, etc.

primitive inefficiencies. Negative stresses on the learner's level of performance due to the inadequate development of nervous system functions which should have matured within the first few years of life.

proprioceptive. Pertaining to the perception of movement of the body parts from stimuli arising within the organism.

pursuits. Following a moving target with both eyes as it moves in various planes; using the eyes to follow along a line of print.

quantitative. Referring to the understanding and use of numbers and their operations, interrelations, combinations, generalizations, etc.

receptive language. Understanding words, sentences, or a body of information of age-appropriate conceptual/grammatical complexity; listening and reading are receptive language modalities.

reciprocal. Moving alternately back and forth.

residual. Remaining or left over.

reversibility. A developmental conceptual process by which transformations such as separation and subtraction are made.

sensory-motor. Sensory refers to receiving stimuli and transmitting it within the nervous system. Motor refers to muscular movements. Sensory input is transmitted through the nervous system to cause a response which can be observed in movement. The sensory and motor systems are seen as affecting each other and depending on each other.

sequelae of trauma. Disease or dysfunction resulting from an accident.

sequence. The correct or logical ordering of one thing or idea after another.

speech therapy. The professional field which deals with the elimination or alleviation of speech defects, such as faulty speech sound production (articulation) or stuttering.

stimuli. Bits of sensory information available in the environment.

stress. Frustration, conflict, and pressure brought about by a multiplicity of demands for academic and social adjustment which the learner cannot meet due to inadequate internal and external resources.

syndrome. A number of symptoms which occur together.

translate. To convert from one state or form to another.

traumatic accident. An injury or wound produced suddenly and/or violently.

verbal expression. The use of words or sentences in speech or in writing, in contrast to other ways of communicating.

vergences. To focus on a moving target as it moves toward and away from the body.

vestibular. Pertaining to the portion of the inner ear which transmits information regarding orientation of the head and body in space, which affects muscle tone, posture and balance.

vicarious. Experiences acquired indirectly through communication and imagination as opposed to direct involvement.

visual attentiveness. The ability to see clearly, singly, and purposefully with efficiency and comfort at near, far or intermediate distances in processing information.

II

STATE OF DELAWARE
GENERAL GUIDELINES FOR THE DEVELOPMENT OF PROGRAMS OF SPECIAL EDUCATION AND RELATED SERVICES FOR CHILDREN AND YOUTH WITH PHYSICAL IMPAIRMENTS

The Delaware Department of Public Instruction

William B. Keene, *State Superintendent*
John J. Ryan, *Acting Deputy State Superintendent*
Assistant State Superintendent
Administrative Services Branch
Randall L. Broyles, *Assistant State Superintendent*
Instructional Services Branch

II

STATE OF DELAWARE
GENERAL GUIDELINES FOR THE DEVELOPMENT OF PROGRAMS OF SPECIAL EDUCATION AND RELATED SERVICES FOR CHILDREN AND YOUTH WITH PHYSICAL IMPAIRMENTS

The Delaware Department of Public Instruction

William B. Keene, *State Superintendent*
John J. Ryan, *Acting Deputy State Superintendent*
Assistant State Superintendent
Administrative Services Branch
Randall L. Broyles, *Assistant State Superintendent*
Instructional Services Branch

The State of Delaware is an equal opportunity employer and does not discriminate or deny services on the basis of race, color, national origin, sex, handicap, and/or age.

Guideline Contributors:

Edward J. Dillon, Ed.D., State Supervisor, Exceptional Children Programs, State Department of Public Instruction (Guidelines Task Force Chairperson)

Jean Beard, Principal (Retired), John G. Leach School

Samuel Cronis, Program Director, Office of Physical and Occupational Therapy, Department of Health and Social Services

Constance A. Halter, Ed.D., Principal, John G. Leach School

Dolores L. Higgins, formerly Program Coordinator, Shortlidge School; presently Principal, Wallace Wallin School

Linda J. Mazepink, formerly Assistant Principal, John G. Leach School; presently Principal, Charles W. Bush School

William A. Suleski, Supervisor of Special Education, Capital School District

Ina Upshur, Coordinator, Sussex County Orthopedic Facility

Betty Warren, Coordinator, Kent County Orthopedic School

Melville Warren, Director, Kent County Orthopedic School

Ann Willson, Supervisor, Office of Physical and Occupational Therapy, Department of Health and Social Services

DEFINITION

Physical Impairment — The child exhibits a physical or health impairment of such extent that it interferes significantly with his/her learning and/or requires adaptation of the physical plant. Under this definition are crippling impairments resulting from interference with the normal functions of the bones, joints, or muscles (orthopedically handicapped), or due to lack of complete development or injury to the central nervous system (neurologically impaired).

(From Section III. G. 3. of the Delaware *Administrative Manual for Programs for Exceptional Children*).

SECTION I. NATURE OF THE EXCEPTIONALITY

The term Physical Impairment encompasses an extraordinary range of handicapping conditions. In this respect, the phrase *physical-motor and related health impairment(s)* may best describe the children and youth with problems in this area. Such terminology includes interferences with the normal functions of the bones and joints (orthopedic handicaps, muscular dystrophy, etc.), congenital anomalies and traumas resulting in severe to profound impairment of the central nervous system (essentially cerebral palsy and spina bifida), maturational delays resulting in prolonged poor muscle control and balance, and chronic health impairments of relatively low incidence (i.e., cardiac conditions, asthma, sickle cell disease, anemia, cystic fibrosis, diabetes, hemophilia, dermatomyositis, etc.). Other low incidence physical-motor impairments may include arthrogryposis, traumatic paraplegia and quadriplegia, juvenile rheumatoid arthritis, amputations, poliomyelitis, severe scoliosis, Legg Perthes Disease, etc.

In a very significant number of incidences of severe physical-motor and related health impairments early manifestations of such handicapping conditions may be present at the pre, peri, neo and post-natal stages of development. Intervention at these very early stages by a specialized interdisciplinary team with in-depth professional expertise at these most primitive developmental levels holds major promise for more effective prevention and habilitation in a great many cases.

In general, beyond the mild levels, physical-motor and related health impairments tend to occur in association with other exceptionalities. In a given child a physical impairment may be present with any other handicapping condition. For example, a physical-motor impairment may be associated with visual and/or hearing impairments, language dysfunctions, mental retardation and learning disability characteristics. The cumulative multiple interactions of such handicapping conditions tend to magnify the developmental learning problems of the physically impaired.

Based on experience, the estimated incidence in Delaware of moderate to profound physical-motor problems and other health impairments in relation to the total school population is estimated to fall in the general area of .35%.

SECTION II. THE EDUCATIONAL CHALLENGE

A comprehensive program of habilitation/compensation must be implemented, as appropriate, for each child or youth to meet the moderate to profound multiple disabilities and related developmental-educational problems which are commonly encountered among the physically impaired. Such a program must be able to provide effective individual interventions and specific support in the development and/or compensation of the abilities to:

- maintain stable, flexible control of the head and the trunk;
- reach, grasp, release and manipulate objects;
- assume/initiate specific postures (lying, sitting, kneeling, standing and squatting) and mobile patterns (creeping, crawling, walking, running, hopping, jumping, rolling) in any task or activity;
- achieve and maintain optimal muscle tone and equilibrium in all activities through the progressive integration of the infantile reflexes within the unfolding patterns of voluntary movement;
- function with stamina through the school day without excessive fatigue;
- attend and respond with ease;
- see, hear, touch, taste and smell with full awareness and discrimination in each modality;
- perceive the world in all its richness through the visual and/or auditory modalities alone;
- function in feeding, toileting, dressing and grooming without immediate assistance;
- listen, speak and gesture;
- organize and use information beyond the immediate concrete level;
- master thoroughly the specific academic skills of reading, writing and computing;
- develop vocational interests and skills.

From the operational standpoint, impressive progress has been made statewide in the early identification and effective habilitation of the physically impaired. Because of this emphasis, the prognosis is better today for many physical impairments than at any time in the past. Coincidentally, because of the intensive early programming, the long-term prognosis is reasonably certain for the majority of children with physical impairments by the end of the primary school years. By this time, all that could be done to achieve the best possible developmental habilitation will have been done. Moreover, at this stage, the child's developmental momentum will be far less malleable than at a much earlier age. Beyond this level, with some exceptions, the program for each child will tend to center pragmatically on the best possible use of his/her available self-help and information processing abilities and compensatory support systems in order to profit as fully as possible from the special adaptations of academic, pre-academic and vocational education.

Among children and youth with physical impairments, problems in muscle tone (too little or too much), posture, movement and vitality are critical. For many such pupils correct and consistent handling and positioning by the total school staff and the parents are essential to prevent the extreme crippling which may occur in individual cases through improper methods of physical management. No concern is more basic to the successful habilitation and/or compensation of the physically impaired.

It is essential, therefore, that the individualized education program (IEP) specify annually the appropriate adaptive equipment and the methods of positioning and handling which are mandatory for a particular child. In addition, the IEP must provide clear, concise guidance concerning the management of the daily regime in the school and in the home to ensure that the cumulative stress and fatigue levels of learning and self-management do not become excessive.

It must be emphasized that physically impaired children and youth experience higher than average levels of stress in meeting the ordinary requirements of the school. For them discomfort is the norm. Their learning requires an extra and frequently heroic effort. Consistency, coordination, and flexibility are of the utmost importance for all who are directly concerned with the needs of children and youth in this area. To the extent that the child experiences minimal discomfort from his handicap, he is better able to attend and to respond effectively in meeting the challenges of education.

From the educational standpoint, physically impaired children will frequently exhibit in an extreme form the information processing dysfunctions found among children and youth with specific learning disabilities. *The individualized education program (IEP) of the physically impaired must make adequate provision for the habilitation and/or compensation of both developmental aspects: the medical handicap(s) and the information processing problem(s).* A full review of the latter aspect will be found in the State of Delaware General Guidelines for the Development of Programs of Special Education and Related Services for Children and Youth with Learning Disabilities.

Finally, other developmental problems are usually associated with the physical impairment. Not infrequently habilitation is more favorable in these associated areas of development than it is in the motor dimension itself. These sectors of strength should be developed to their fullest potential wherever possible. They could make the difference between a life of dependency and some degree of independence.

SECTION III. BASES FOR PLACEMENT

Placement of a child or youth with a physical impairment in any educational setting is a specific educational responsibility. The Individualized Education Program (IEP) determines such placement.

A. *Specialized Interdisciplinary Systems—Statewide/Regional Special Schools and Facilities, Intensive Learning Centers, Institutional Settings*

Placement in a specialized interdisciplinary system is essential when the complexity and intensity of the handicapping condition(s) requires a total closely coordinated day-to-day intervention by a specialized interdisciplinary team with the in-depth expertise and specific commitment to the habilitation and/or compensation of physical-motor and related health impairments.

From the standpoint of long-term case management, any child whose diagnosis confirms a severe to profound physical impairment should be placed initially in a service center designed to provide a full scope intervention for physical-motor and related health impairments. Administrative arrangements will be initiated by the center principal or coordinator for appropriate supportive services in the associated (multiple) handicapping condition(s). *Such placement will continue until the time when placement in another center or in the regular school program is more appropriate.*

B. *Mainstream Continuum of Services (With Multidisciplinary Support)—Regular Classes, Resource Rooms, Special Class Settings*

Placement in the mainstream continuum of services cannot be determined simply by the degree of physical impairment. The issue for each individual is whether on the basis of the aptitude, maturity and motivation of the student and the efficiency of his/her unique adjustments for self-management and information processing, participation in and profit from the regular school program is possible. In this respect a severely crippled pupil may in time be mainstreamed successfully if there has been appropriate progress in intensive special education and therapy and if there is reasonable flexibility and adaptation on the part of the receiving regular school staff, especially in the area of specialized transportation, building and program accessibility, health services, self-management in the daily regime, and communication devices.

SECTION IV. THE DELIVERY OF SPECIAL EDUCATION AND RELATED SERVICES

A. *Identification and Diagnosis*

The initial identification and diagnosis of a physical impairment and the prescription of physical therapy and occupational therapy is a medical responsibility. Such responsibility includes appropriate medical follow-along and re-evaluation for each child.

B. *The Individualized Education Program (IEP)*

The development and application of an individualized education program (IEP), including special education and related services, is the professional responsibility of the specialized interdisciplinary team for the physically impaired. *In a special school or facility for this group, such responsibility is an administrative charge and accountability of the designated principal or coordinator.*

In the mainstream continuum of services, accountability for the physically impaired is a joint responsibility. Two areas of concern must be integrated—that of the assigned field program coordinator from the orthopedic special school whose immediate concern is the welfare of the individual physically impaired child or youth placed in the mainstream and that of the regular building principal whose immediate concerns relate to the total operation of the mainstream facility and its program. At this level, systematic provision must be made for a unified effort by special and regular educators on behalf of each physically impaired child or youth.

With respect to the assessment and diagnosis of the physical impairment, all observations and findings must be creative, sensitive and formative in order to provide an accurate description of the unique nature of the child's developmental disability, including an analysis of his/her actual achievement levels as well as realistic estimates of the critical potentials for learning.

Because of the unique and frequently extreme variances manifest in the development of each child with a physical impairment, it is essential that the specialized interdisciplinary team coordinate all its observations and findings systematically through a developmental profile as the basis for the individualized education program (IEP) and for continuous, long-term pupil progress accountability.

C. *Program Structure*

1. *Specialized Interdisciplinary Systems—Statewide/Regional Special Schools and Facilities, Intensive Learning Centers, Institutional Settings*

   a. *Leadership*

   Because of the extraordinary complexity of the developmental-educational problems encountered at the severe to profound levels among pupils with physical-motor and other health impairments, it is essential that each special school or facility in this area be supervised directly by a qualified administrator or coordinator whose primary responsibility is the development, implementation and evaluation of such program.

b. *Facility Spaces*

Each special school or facility for the physically impaired should include:

- instructional areas;
- administrative spaces;
- therapy areas (including physical and occupational therapy and speech/language);
- appropriate physical education areas for adaptive programming;
- health center;
- prevocational training area (shops, home arts components, etc.);
- adapted bathrooms;
- comprehensive media center (library, curriculum A-V components, etc.);
- adapted transportation system. (The delivery of special education and related services to the physically impaired depends in no small measure on the establishment of an appropriate, efficient transportation system. Provision must be made for such essentials as mechanical lifts and safeguards, the training of all personnel and parents in the proper handling of the children and the special adaptation of seating for individual problems.)

c. *Staff Composition*

Specific provision must be made for an adequate level of services in each of the following areas:

- special education (teachers for the physically impaired and aides);
- physical and occupational therapy (therapists and aides);
- speech therapy (therapists and aides);
- prevocational education (teachers and aides);
- educational-medical records coordination (as assigned);
- mainstreaming coordination (field coordinator, as assigned).

Provision for social work, guidance, library administration, art and music instruction, school psychology and physical education will be determined and recommended by the principal or coordinator in charge based on the needs of the assigned pupil population.

d. *Program Components*

The full-service facility for the physically impaired will provide a total program in appropriate handling and positioning *for each child or youth* to prevent the extreme deformities which occur when improper methods and equipment are utilized over a period of time. In addition, a full range of habilitative and compensatory training activities will be provided (with initial emphasis on the developmental educational masteries from birth to 18 months) in the areas of postural equilibrium, locomotion, manual dexterity and haptic awareness, visual attentiveness, gustatory-olfactory awareness, oral motor competence, language acquisition, and the personal-social competencies of the learner. At the appropriate times, *for each child,* graphics, mathematics, the language arts and adaptations of the regular content areas will be incorporated in his/her program.

In effect, the curriculum of the school is shaped by the IEPs of its pupils. *The delivery of program services will necessarily emphasize flexible small group arrangements and individualization.*

e. *Program Coordination*

Special education and related services for the physically impaired in a total service setting must be provided through a systematic, interdisciplinary team approach in which each discipline has an obligation to contribute to the development and implementation of the individualized education program (IEP) plan. Within such framework, each child or youth will be identified in one of four service categories:

(1) Requires placement in a special school with the full scope of special education and related services provided by an interdisciplinary team with in-depth expertise in the habilitation and compensation of the physically impaired (usually during the preschool and primary years);

(2) Requires placement in a special school with immediate partial interdisciplinary team support of the type indicated in (1) above, but with a teacher of the physically impaired being the primary service provider (usually at the middle school level and beyond);

(3) Requires placement in the mainstream with immediate, but partial special education services from a teacher of the physically impaired and follow-along supervision by a field program coordinator from the special school or facility;

(4) Requires placement in the mainstream with initial coordination and, if requested, follow-up consultation provided by the special school, but with no further provision for special education.

2. *Mainstream Continuum of Services (with Multidisciplinary Support) — Regular Classes, Resource Rooms, Special Class Settings*

In general, it is neither sound nor cost effective to attempt to implement in the mainstream a full scale interdisciplinary program for the physically impaired. However, the following provisions are appropriate to the mainstream service continuum as well as to other special school or institutional programs:

- the establishment of a special class or resource room uniquely adapted to the needs of the physically handicapped can provide a controlled intermediate step in the mainstreaming of pupils from a special school or institution;
- implementation of systematic follow-along coordination can provide practical support for individual pupils with physical handicaps placed in the mainstream continuum or in another specialized interdisciplinary system, such as a special school for the mentally retarded or an institution.

Finally, to ensure the effective implementation of individualized education programs in the least restrictive alternative for all physically impaired children or youth, it is essential that specialized interdisciplinary systems and the mainstream continuum be coordinated statewide in well-organized regional networks for service delivery. To this end, wherever possible, mainstream program components for the physically impaired, such as special resource rooms or classes, should be established in close physical proximity to the special school or facility with specialized interdisciplinary expertise in this area. *When such sites are too widely dispersed, the problems of administration and program coordination are dramatically magnified to the immediate detriment of the handicapped child.*

SECTION V. STAFF PROFESSIONAL GROWTH

The general guideline structure for the professional growth of the inter-disciplinary staffs serving the physically impaired provides a systematic framework for on-going inservice programs which are essential to consistent program quality development and control.

Statewide inservice systems are designed to support this local training process through special study institutes to develop administrative and program leadership personnel and the specific technical components not available through other sources.

A. *Specialized Interdisciplinary Systems — Statewide/Regional Special Schools and Facilities, Intensive Learning Centers, Institutional Settings*

1. *General Program Orientations*
   - In each special facility for the physically impaired, including its outreach components (resource rooms) in the mainstream, there should be provision annually for the total staff to become familiar with current, pertinent Federal, State and local regulations, policies and priorities.
   - Similar provision should be made for communication of the various program components of the special facility so that all personnel are aware of the total program.
2. *Specific Program Implementations*
   - Provision should be made annually for the involvement of appropriate staff members in the implementation, review and modification or renewal of the major program components of the facility.
   - Thorough arrangements should also be made for on-going briefings and child study team interactions essential to the effective implementation of the individualized education programs for the facility pupil population.
3. *Topical Presentations*
   - Periodic presentations by key interdisciplinary staffs who have participated in recent statewide inservice programs are essential to augment the knowledge base of the total facility staff concerning the rapid advances in technology which can improve the habilitation and/or compensation of the physically impaired. Such presentations should emphasize in particular the habilitative and compensatory implications of developmental arrest from birth through 36 months of developmental age in the areas of motor-perceptual development, language acquisition and integration and the basic survival competencies of self-help skills and adjustment to learning situations. The area of proper physical management in handling and positioning will always be a basic concern for this population.
4. *Model Studies of Individual Children and Youth*
   - As an integral follow-up to statewide inservice programs, one or more visits, preferably on an annual basis, by nationally recognized inter-

disciplinary specialists in the habilitation/compensation of the physically impaired can expand the expertise of the local interdisciplinary team through collaborative, in-depth studies of selected problems in program implementation.

- Total staff can also benefit on an awareness level from facility-wide feedback and/or participation in such studies.

5. *Professional Practica*

   - Ordinarily, the type of extended practicum experience afforded by the universities in technical program areas is not appropriate to an inservice program. For the physically impaired, however, selective annual participation by key leadership staff (teachers and physical, occupational and speech/language therapists) on a rotating basis can do much to upgrade the quality of program resources in a particular facility.

6. *Product Workshops*

   - From time-to-time, special inservice institutes may be necessary to develop assessment or program materials specifically for the facility.

B. *Mainstream Continuum of Services (With Multidisciplinary Support) — Regular Classes, Resource Rooms, Special Class Settings*

1. *General Program Orientations*

   - If the mainstreaming of individual students is to work effectively, concise orientations must be provided by the staffs of the special school or facility and the mainstream site to ensure an adequate information base for efficient communication.

2. *Specific Program Implementations*

   - Annual provision must be made for the briefing and involvement in planning of regular staffs responsible for implementation of the individualized education program (IEP) of any child or youth placed in the mainstream.

3. *Topical Professional Presentations*

   - Selective participation by mainstream staffs in specific topical presentations can be very helpful. Practical presentations related to physical management in handling and positioning should be required in certain situations.

SECTION VI. REFERENCES

Bleck, Eugene E., M.D. & Donald A. Nagel, M.D., *Physically Handicapped Children—A Medical Atlas for Teachers,* Grune & Stratton, New York, 1975.

Child Accountable Developmental Evaluation & Teaching Systems (CADETS), Department of Public Instruction, Dover, Delaware, 1976.

Finnie, Nancie R., *Handling the Young Cerebral Palsied Child at Home,* E. P. Dutton & Co., New York, 1975.

Gesell, A. and C.S. Amatsuda, *Developmental Diagnosis,* 2nd ed., Hoebner, New York, 1947.

Gesell, A. et al., *The First Five Years of Life—A Guide to the Study of the Preschool Child,* Harper & Row, New York, 1940.

Illingsworth, R. D., *The Development of the Infant and Young Child, Normal and Abnormal,* 5th ed., Williams & Wilkins, Baltimore, 1972.

Reynolds, M.C. and J. W. Birch, *Teaching Exceptional Children in All America's Schools,* Council for Exceptional Children, Reston, Virginia, 1977.

SECTION VII. GLOSSARY

amputation. Surgical or accidental removal of a limb or appendage.

arthrogryposis. A congenital disease involving stiff and curved joints.

asthma. A disease due to spasmodic contraction of the bronchi because of allergies or other irritations, resulting in wheezing, coughing, and paroxysmal panting.

cerebral palsy. A non-progressive disorder of movement and coordination caused by cerebral defect or injury in infancy and childhood.

convulsive. Producing or resulting in convulsions involving spasmodic and violent muscle contractions and loss of consciousness.

cystic fibrosis. A disease involving defective production of enzymes in the pancreas, with disturbances throughout the body.

dermatomyositis. Inflammation of the skin, tissue, and underlying muscle.

diabetes. A metabolic disorder resulting in faulty production of insulin, leading to high blood sugar levels, loss of weight, and coma.

gustatory-olfactory awareness. The abilities to identify the perceptual qualities of flavor and/or odor associated with foods and other objects.

haptic awareness. The abilities to discriminate through involvement and touch variations in the configuration, weight, temperature, texture and pressure of objects.

hemophilia. A disorder in which the blood fails to clot following injury or bruising.

interdisciplinary. Refers to the coordinated delivery of special education and related services by teachers and specialists working together as a team in the development and implementation of the individualized education program (IEP).

language acquisition. The abilities to acquire, use and understand patterns of sound, body language, words, and sentences.

Legg-Perthes disease. A degenerative disease of the ball of the hip bone or femur.

locomotion. Purposeful movement from place to place in a variety of ways: crawling, creeping, rolling, walking, running, etc. (Flexible equilibrium responses accompany all movement. Such responses are sometimes referred to as dynamic equilibrium.)

manual dexterity. Efficient eye-hand coordination in reaching, grasping, manipulating and releasing objects and in catching and throwing. (A preferred hand is established. The non-preferred hand supports the efficiency of the preferred or lead hand.)

multidisciplinary. Professional specialists consult with the instructional staff periodically or as special needs require.

muscular dystrophy. A disease involving progressive shrinking and wasting of skeletal muscle with no apparent lesion of the spinal cord, the symptoms usually manifesting themselves in early childhood or adolescence.

neonatal. Relating to the newborn, especially during the first months of life.

oral-motor competence. Efficient voluntary control of the anatomical structures essential to breathing, eating and drinking.

paraplegia. Paralysis of the legs and lower part of the body.

perinatal. Occurring at or pertaining to the time of birth.

personal-social competence. The abilities to care for self and to function with age-appropriate maturity in the roles of son/daughter, peer, pupil, employee, citizen, etc.

poliomyelitis. An acute viral disease invading the nerve cells in the spinal cord or brain resulting in paralysis or muscular atrophy.

postnatal. Occurring after birth.

postural equilibrium. Immediate flexible adaptation to the force of gravity in a variety of postures: lying, sitting, kneeling, squatting, standing, etc.

prenatal. Occurring or existing before birth.

quadriplegia. Paralysis of both arms and both legs.

rheumatoid arthritis. A chronic disease of the joints accompanied by deformities, inflammatory changes in the membranes and joints, and wasting of the bones.

scoliosis. A lateral curvature of the spine.

sickle cell anemia. A form of anemia characterized by sickle cells and abnormal hemoglobin accompanied by abdominal pains, ulceration of legs, and bone pain.

spina bifida. A meningeal protrusion through a congenital cleft in the bony encasement of the spinal cord.

trauma. A wound or injury.

visual attentiveness. The ability to see clearly, singly, and purposefully with efficiency and comfort at near, far or intermediate distances in processing information.

STATE OF DELAWARE
GENERAL GUIDELINES FOR THE DEVELOPMENT OF PROGRAMS OF SPECIAL EDUCATION AND RELATED SERVICES FOR CHILDREN AND YOUTH WITH MENTAL RETARDATION

The Delaware Department of Public Instruction

William B. Keene, *State Superintendent*
John J. Ryan, *Acting Deputy State Superintendent*
Assistant State Superintendent
Administrative Services Branch
Randall L. Broyles, *Assistant State Superintendent*
Instructional Services Branch

STATE OF DELAWARE
GENERAL GUIDELINES FOR THE DEVELOPMENT OF PROGRAMS OF SPECIAL EDUCATION AND RELATED SERVICES FOR CHILDREN AND YOUTH WITH MENTAL RETARDATION

The Delaware Department of Public Instruction

William B. Keene, *State Superintendent*
John J. Ryan, *Acting Deputy State Superintendent*
Assistant State Superintendent
Administrative Services Branch
Randall L. Broyles, *Assistant State Superintendent*
Instructional Services Branch

The State of Delaware is an equal opportunity employer and does not discriminate or deny services on the basis of race, color, national origin, sex, handicap, and/or age.

Guideline Contributors:

Barbara E. Humphreys, State Specialist, Exceptional Children Programs, Diagnostician, State Department of Public Instruction (Guideline Task Force Chairperson)

Betty Bergstrom, Teacher, Meadowood School

Cammie Cairns, Teacher, Wallace Wallin School

Dr. Byron Chandler, Principal, Joseph E. Douglass School

Jean Cripps, Community Nursing and Development Program, Division of Mental Retardation

Joseph Price, Supervisor of Special Services, New Castle County School District, Area I

DEFINITION

Mental Retardation — refers to significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior, and manifested during the developmental period. (From *AAMD Manual on Terminology and Classification in Mental Retardation*, Grossman, 1973.)

The terms educable mentally handicapped, trainable mentally handicapped, and severely mentally retarded are used in Delaware's special education programs for purposes of classification.

Note—The terms "Mental Retardation" and "Mental Handicap" are used synonymously in this document.

SECTION I. NATURE OF THE EXCEPTIONALITY

Generally, an individual must have an IQ of below 70 or 75 to be considered mentally retarded. However, the IQ by itself is of little significance for purposes of program development. Information that contributes to defining the current functioning level of the individual is essential if appropriate programs are to be designed and valid goals and objectives are to be developed. The determination of current functioning level permits the establishment of realistic planning based upon what the mentally retarded individual can be expected to achieve.

It is important to realize that approximately 3% of the total population may be diagnosed as mentally retarded. Of the total number of mentally retarded individuals, approximately 85% fall into the mild range of retardation and can be expected to develop the skills necessary for independent community living. The remaining 15% fall into the moderate, severe, and profound ranges and will require some degree of supervision throughout their lives. This portion of the population will be dependent upon others, to varying degrees, in relation to all community living functions.

Finally, it must be realized that as the severity of mental retardation increases, the likelihood of multiple handicaps increases. Such handicaps include physical, visual, auditory, speech, emotional, and specific medical impairments and they require the services of many specialized professional staff. Though the multihandicapped population is small in comparison to the total population of the mentally retarded, they demand a large share of the available resources (staff, materials, equipment, etc.). Thus, the mentally retarded are a population that demonstrate a wide range of abilities, requiring a variety of programs, conducted by specialized personnel who have access to a wide variety of required resources.

SECTION II. THE EDUCATIONAL CHALLENGE

The term mentally retarded infers that the mental processes are slowed in their rate of development. However, there are learning characteristics (weaknesses and abilities) that have been identified in this population (Smith, 1977).

Characteristic learning weaknesses include:

- poor short term memory;
- short attention span;
- slow reaction time;
- slowness to learn incidentally from peripheral stimuli;
- slowness in spontaneous productive thinking;
- deficit in ability to deal with abstractions.

However, the mentally handicapped are able to:

- memorize when constant use of overlearning and reinforcement is employed;
- develop an understanding of sequentially presented facts and concepts;
- learn to discriminate when stimuli are named, labeled, and novel;
- learn from concrete instructional presentations in which materials can be manipulated.

Thus, the educational challenge lies in the recognition of the learning characteristics of the mentally retarded and programming to utilize areas of strength to overcome areas of weakness. In approaching this task, the professional must be well prepared. Such preparation should include the development of a familiarity with the process of behavior modification techniques and the process of task analysis. The application of this knowledge within a developmental framework should enable the teacher to assist the student to achieve his/her maximum potential.

SECTION III. BASES FOR PLACEMENT

A. *Specialized Interdisciplinary Systems—Statewide/Regional Special Schools and Facilities, Intensive Learning Centers, Institutional Settings*

Placement in a more restrictive alternative is essential when the complexity and intensity of the mentally handicapping condition(s) require a highly structured and closely supervised program provided by a specialized teaching team, in coordination with the therapists who supply related services, such as speech, hearing, physical, and occupational therapy.

From the standpoint of long-term case management, any child whose diagnosis confirms a severe to profound mental impairment should be placed initially in a service facility designed to provide a full scope intervention for such children. Administrative arrangements will be initiated by the facility principal or coordinator for appropriate supportive services in the associated (multiple) handicapping conditions(s). This placement will continue until the time when placement in another special school, or in the regular school program, is more appropriate.

B. *Mainstream Continuum of Services (with Multidisciplinary Support)—Regular Classes, Resource Rooms, Special Class Settings)*

Placement in a less restrictive alternative will be determined by the degree of mental handicap in conjunction with the level of social, emotional, and physical development and the factors of adaptability and adjustment. The issue in each case is whether, on the basis of the aptitude, maturity, and motivation of the student, and the efficiency of his/her unique adjustments for self-management and information processing, participation in, and profit from, the regular school program is possible. In this respect, a mentally handicapped pupil may in time be mainstreamed successfully if there has been appropriate progress in intensive special education and therapy and if there is reasonable flexibility and adaptation on the part of the receiving regular school staff.

SECTION IV. THE DELIVERY OF SPECIAL EDUCATION AND RELATED SERVICES

A. *Identification and Diagnosis*

The initial identification and diagnosis of a mental handicap must be confirmed by formal individualized testing by a qualified psychologist or psychometrist who then submits a formal written report.

B. *The Individualized Education Program (IEP)*

The development and application of an individualized education program (IEP), including special education and related services, are the professional responsibility of the child study team. This responsibility is an administrative responsibility. In a more restrictive level, accountability rests with the principal or coordinator of the special school or facility for the mentally handicapped. In a less restrictive level, such accountability rests with the building principal where the pupil has been placed. In either situation, immediate coordinative responsibility for the IEP may be delegated to an appropriate staff member.

With respect to the processes of assessment and diagnosis on each level of mental handicap, all observations and findings must be creative, sensitive, and formative in order to provide an accurate description of the unique nature of the developmental disability, including an analysis of actual achievement levels as well as informed estimates of the critical potentials for learning. It is essential that the child study team coordinate all their observations and findings systematically as a basis for the individualized education program (IEP) and continuous long-term pupil progress accountability.

C. *Program Structure*

1. *Specialized Interdisciplinary Systems—Statewide/Regional Special Schools and Facilities, Intensive Learning Centers, Institutional Settings*

a. *Leadership*
Because of the extraordinary complexity of the developmental-educational problems encountered at the severe to profound levels among pupils with mental handicaps, it is essential that each special school or facility in this area be supervised directly by a qualified administrator or coordinator whose sole responsbility is the development and implementation of such a program.

b. *Facility Spaces*
Each special school or facility for the mentally handicapped should include (or provide access to) the following:

- instructional areas with adequate storage;
- administrative spaces;
- therapy areas (including physical and occupational therapy and speech/language);

- physical education areas (including adaptive physical education, swimming pool for therapy and water safety skills, and outside adapted playground);
- health center;
- prevocational and vocational training area (shops, home/community living skills, food service, greenhouse, etc.);
- adapted bathrooms;
- comprehensive media center (library, curriculum A-V component, etc.);
- food service area;
- staff lounge;
- additional storage space.

c. *Staff Composition*

Specific provision should be made for an adequate level of services provided by appropriately trained staff in each of the following areas:

- special education for the mentally retarded;
- physical and occupational therapy;
- psychological services;
- speech theapy;
- art and music instruction;
- guidance services;
- prevocational and vocational education, e.g., food service, horticulture, shop, and home/community living skills;
- physical education;
- educational-medical records coordination;
- comprehensive media services;
- health education and related activites;
- home/school coordination;
- food service.

d. *Program Components*

The full service facility for mentally handicapped children should provide opportunities for the development of self-help skills, social skills, motor (gross and fine) skills, pre-academic and academic skills, communication skills, prevocational and vocational skills, and home/community living skills.

In addition, lifetime leisure skills, independent living skills, community awareness, and sex education should be incorporated into the program.

Multiply handicapped children should receive additional services from resident and itinerant staff to meet their educational and related services needs as indicated in their IEP, e.g., a mentally handicapped child with cerebral palsy.

If there is to be generalization of the skills learned in the classroom, it is of critical importance that there be significant parent involvement in the program. This may be accomplished through one or more of the following options:

- classroom observations and conferences;
- classroom participation;
- telephone contacts;
- notebooks (between school and home);
- home visits;
- involvement with other agencies;
- parent meetings;
- parent task forces.

e. *Program Coordination*

Special education and related services for the mentally handicapped in a total service setting must be provided through a systematic, interdisciplinary team approach in which each discipline has an obligation to contribute to the development and implementation of the individualized education program (IEP).

Interagency cooperation must be developed and maintained whenever mentally handicapped persons are served by public or private agencies in addition to public schools. Provision should be made for evaluations, both written and oral, to ensure that the sending agency is kept informed of pupil progress and areas of continued need.

2. *Mainstream Continuum of Service (with Multidisciplinary Support) — Regular Classes, Resource Rooms, Special Class Settings*

a. *Leadership*
Students with mental handicaps who are able to function within the framework of a regular educational setting will have their program supervised by the qualified administrator or coordinator of the school which they attend in cooperation with the district supervisor of special education.

b. *Facility Spaces*
Each school where mildly or moderately mentally handicapped children attend should include (or provide access to) the following:

- instructional areas;

- administrative spaces;
- therapy areas (including physical and occupational therapy and speech/language);
- physical education areas (including adaptive physical education);
- health center;
- prevocational and vocational training area (shops, home arts, food service, greenhouse, etc.);
- adapted bathrooms;
- comprehensive media center (library, curriculum A-V components, etc.).

c. *Staff Composition*
Specific provision should be made for an adequate level of services provided by appropriately trained staff in each of the following areas:

- regular education;
- special education for the mentally retarded;
- physical and occupational therapy;
- work/study coordination;
- psychological services;
- speech therapy;
- art and music instruction;
- prevocational and vocational education, e.g., food service, shop, home/community living skills, and horticulture;
- physical education;
- home/school coordination;
- guidance;
- comprehensive media services.

Additional specific services may be provided for a child whose IEP indicates such services are needed.

d. *Program Components*

The program for mildly mentally handicapped students who are attending regular education classes should be expanded to include prevocational and vocational skills, independent living skills, lifetime leisure skills, and sex education. Related services should be provided when so indicated by the IEP.

e. *Program Coordination*

Special education and related services for the mildly mentally handicapped in a regular educational setting must be provided through a systematic, interdisciplinary team approach in which each discipline has an obligation to contribute to the development and implementation of the individualized education program (IEP). Interagency cooperation must be developed and maintained whenever mentally handicapped persons are served by public or private agencies in addition to public schools. Provision should be made for evaluations, both written and oral, to ensure that the sending agency is kept informed of pupil progress and areas of continued need.

SECTION V. PROFESSIONAL GROWTH.

Professional growth for staffs working with the mentally handicapped has been, and continues to be, the responsibility of both the local education agency (LEA) and the state education agency (SEA). Staffs should also be provided with the opportunity to attend significant out-of-state conferences and workshops which are pertinent to their professional needs.

Conferences of the American Association on Mental Deficiency, the American Association for the Education of the Severely/Profoundly Handicapped, and the Council for Exceptional Children offer a wide variety of programs of particular interest to teachers of the mentally handicapped.

A. *Specialized Interdisciplinary Systems—Statewide/Regional Special Schools and Facilities, Intensive Learning Centers, Institutional Settings*

1. *General Program Orientations*

- In each special facility for the mentally handicapped, including its outreach components in the mainstream, there should be provision annually for the total staff to become generally familiar with current, pertinent Federal, State, and local regulations, policies, and priorities.
- Similar provision should also be made for communication among the various program components of the special facility so that all personnel are aware of the total program and their relationship to it.

2. *Specific Program Implementations*

- Provision should be made annually for the involvement of appropriate staff members in the implementation, review, and modification or renewal of the major program components of the facility.
- Thorough arrangements should also be made for the on-going briefings and the child study team interactions essential to the effective implementation of the individualized education programs (IEPs) for the pupil population of the facility.

3. *Topical Professional Presentations*

Special school staff who serve the mentally handicapped should be provided the opportunity to attend inservice programs both locally and Statewide.

Specific attention should be given to the following topics:

- IEP development with emphasis on the tools and techniques of individual assessment, task analysis, and statements of annual goals and objectives in behavioral terms;
- instruction in how to teach social skills, judgments, and alternative behaviors;
- understanding the sexual needs of the handicapped and how to meet these needs;

- training in the development of prevocational skills for the mentally handicapped at the primary level;
- understanding of, and working with, families of mentally retarded children;
- training in the physical management of handling, positioning, and feeding those children with multiple handicapping conditions;
- specific training programs developed for paraprofessional staff;
- training in working with mentally handicapped children with concomitant social/emotional problems.

B. *Mainstream Continuum of Services (With Multidisciplinary Support)—Regular Classes, Resource Rooms, Special Class Settings*

1. *General Program Orientations*

If the mainstreaming of individual pupils is to work effectively, concise orientations must be available from the special school and from the mainstream facility to provide an adequate information base for efficient communication by the respective staff members from each site.

2. *Specific Program Implementations*

Adequate provision must be made in every case for a thorough briefing to the mainstream staffs concerning the individualized education program (IEP) of each child/youth selected for this experience.

3. *Topical Professional Presentations*

In mainstreaming, it is essential that all staff understand the needs of the handicapped and have respect for their abilities and achievements.

In addition, the staff should be familiarized with the current techniques of group dynamics to assure the acceptance of all children into regular classrooms. Such acceptance is dependent upon the extent to which regular classmates understand the nature and needs of handicapped students who are mainstreamed. In this respect, specific efforts by special and general educators are required to provide students with factual information about classmates who, although mentally retarded, are very much like themselves in many respects.

Specific attention should be given to the following appropriate topics:

- IEP development with emphasis on the tools and techniques of individual assessment, task analysis, and statements of annual goals and objectives in behavioral terms;
- instruction in how to teach social skills, judgments, and alternative behaviors;
- understanding the sexual needs of the handicapped and how to meet these needs;
- training in the development of prevocational skills for the mentally handicapped at the primary level;
- understanding of, and working with, families of mentally retarded children;

SECTION VI. REFERENCES

Department of Public Instruction, Delaware. *Administrative Manual for Programs for Exceptional Children*. October, 1977.

Dreikurs, R., B. Grunwald, and F. Pepper. *Maintaining Sanity in the Classroom*. Harper and Row, New York, 1971.

Grossman, Herbert J., M.D., Ed. *Manual on Terminology and Classification in Mental Retardation*. American Association on Mental Deficiency, Special Publication Series No. 2, 1973 Revision.

Hare, Betty A. and James M. *Teaching Young Handicapped Children: A Guide for Preschool and the Primary Grades*. Grune and Stratton, New York, 1977.

Jennings, Helen Hall. *Sociometry in Group Relations*. American Council on Education, Washington, D.C., 1959.

Schwartz, Lita L. *The Exceptional Child*. Wadsworth Publishing Company, Inc., Belmont, California, 1975.

Smith, Robert. *Clinical Teaching—Methods of Instruction for the Retarded*. Second Edition, McGraw-Hill, New York, 1977.

Sontag, Edward, Ed. *Educational Programming for the Severely and Profoundly Handicapped*. Special Publication of the Division on Mental Retardation, The Council for Exceptional Children, Reston, Virginia, 1977.

Spivack, George, Jerome J. Platt, and Myrna B. Shure. *The Problem-Solving Approach to Adjustment*. Jossey Bass, San Francisco, 1976.

Spivack, George and Myrna B. Shure. *Social Adjustment of Young Children*. Jossey Bass, San Francisco, 1973.

Thomas, M. Angele, Ed. *Hey, Don't Forget About Me!* A report from the Council for Exceptional Children, Reston, Virginia, 1976.

Thorn, Emily. *Teaching for Optimum Human Development*. Family Education Center of Delaware, Inc., 4900 Concord Pike, Wilmington, Delaware 19803, 1976.

SECTION VII. GLOSSARY

adaptive physical education. Physical education which has been changed to meet the needs of the handicapped child as specified in his Individualized Education Plan (IEP).

child study team. A team of administrators, teachers, specialists, and parents who work together to determine the handicapped child's individual needs, based on testing, and to develop his IEP.

developmental profile. An outline of the handicapped child's ability in all areas of development, i.e., physical, mental, social, and language.

group dynamics. The process of changing the pattern of behavior within a group.

mainstream. An educational process of maintaining or returning exceptional students, who can best profit from such placement, to the regular education classroom with all needed supportive services provided.

mental retardation (mentally handicapped).

educable: Shall range between 75 and 50 I.Q. points inclusive. Maturation and development up to age 5 may be described as limited or poor social awareness, fair motor development, ability to talk and communicate, need for greater self-help skills, manageable with moderate supervision. Training and development from 6 to 21: able to learn functional academic skills; cannot learn general high school subjects.

trainable: Shall range between 55 and 35 I.Q. points. Maturation and development from 0 to age 5: speech is minimal; little or no communication skills; generally unable to perform independently. Training and development from 6 to 21: can learn to talk and communicate; can learn elementary health habits; cannot learn functional academic skills; profits from systematic habit training.

severely mentally handicapped: Shall be in the range below 35 I.Q. points. Maturation and development from 0 to age 5: Gross retardation; minimal capacity for functioning in sensori-motor areas; needs nursing care. Training and development from 6 to 20 inclusive: Some motor development present; is incapable of being trained in total self-care, socialization, or economic usefulness, and needs continued help in taking care of personal needs.

occupational therapist. Person trained to build the skills of the handicapped child's needs in daily living, such as feeding, dressing, and play.

physical therapist. Person trained to develop strength, endurance, and normal movement patterns so that the child may become as independent as possible.

pre-vocational skills. Skills which are required by a person prior to his/her admission to a vocational program (e.g., social skills, self-help skills, etc.)

related or supportive services. According to P.L. 94-142: "transportation and such developmental, corrective and other supportive services as are required to assist a handicapped child to benefit from special education and includes speech pathology and audiology, psychological services, physical and occupational therapy, recreation, early identification and assessment of disabilities in children, counseling services for diagnostic or evaluation purposes. The term also includes school health services, social work services in schools, and parent counseling and training."

special education teacher. Person trained to assess and provide for learning needs of a child so that child can experience success and learn to his fullest potential.

task analysis. The breaking down of instructional objectives into a series of phases (sub tasks) and the further delineation of those phases into component parts.

STATE OF DELAWARE GENERAL GUIDELINES FOR THE DEVELOPMENT OF PROGRAMS OF SPECIAL EDUCATION AND RELATED SERVICES FOR CHILDREN AND YOUTH WITH SPEECH AND LANGUAGE DEFICITS

The Delaware Department of Public Instruction

William B. Keene, *State Superintendent*
John J. Ryan, *Acting Deputy State Superintendent*
Assistant State Superintendent
Administrative Services Branch
Randall L. Broyles, *Assistant State Superintendent*
Instructional Services Branch

STATE OF DELAWARE GENERAL GUIDELINES FOR THE DEVELOPMENT OF PROGRAMS OF SPECIAL EDUCATION AND RELATED SERVICES FOR CHILDREN AND YOUTH WITH SPEECH AND LANGUAGE DEFICITS

The Delaware Department of Public Instruction

William B. Keene, *State Superintendent*
John J. Ryan, *Acting Deputy State Superintendent*
Assistant State Superintendent
Administrative Services Branch
Randall L. Broyles, *Assistant State Superintendent*
Instructional Services Branch

The State of Delaware is an equal opportunity employer and does not discriminate or deny services on the basis of race, color, national origin, sex, handicap, and/or age.

Guideline Contributors:

- * Dolores M. Pittelli, State Specialist, Delaware Direction Service Center, Department of Public Instruction (Guideline Task Force Chairperson)
- * Connie I. Allen, Ed.D., State Supervisor, Exceptional Children Programs, Department of Public Instruction
- * Barbara Baldwin, Speech Pathologist, Seaford School District
- Jeri Clark, Speech Pathologist, Indian River School District
- Betsy DeMond, Speech Pathologist, New Castle County School District, Area IV
- * Jack Fisher, Director, Office of Speech and Hearing Services, Delaware Division of Public Health
- * Richard French, Supervisor of Special Education, New Castle County School District, Area IV
- * Helen M. Holleger, State Supervisor, Exceptional Children Programs, Department of Public Instruction
- Marlys Kerr, Speech Pathologist, New Castle County School District, Area II
- Sylvia Oken, Speech Pathologist, New Castle County School District, Area I
- * Elizabeth Schantz, Speech Pathologist, Office of Speech and Hearing, Delaware Division of Public Health
- Nancy Suleski, Speech Pathologist, Capital School District
- F. Eugene Thomure, Ph.D., Director, Margaret S. Sterck School for Hearing Impaired, New Castle County School District

*Core Draft Team

DEFINITION:

Speech and/or Language Impairment—The child exhibits a disorder of oral communication exhibited in articulation, voice, rhythm, or verbal language to such a degree that it interferes with self-expression, ability to comprehend the child's speech, or causes the child to become maladjusted.

(From Section III. G. 4. of the Delaware *Administrative Manual for Programs for Exceptional Children*.)

SECTION I. NATURE OF THE EXCEPTIONALITY

The term speech and language impaired includes a wide range of handicapping conditions. The term includes mild deviations that do not alter the "normal" lifestyle of the student (minor articulation and grammatical errors), moderate disorders that cause significant inefficiencies in communication (multiple misarticulations, syntactic problems, auditory discrimination deficits), and severe disorders that profoundly affect not only the lifestyle of the student, but his family as well (vocal fold paralysis, cerebral palsy, cleft palate, severe fluency distress, childhood aphasia, and neurological impairment). Speech and language disorders do not necessarily occur in association with other exceptionalities. Exceptions would be broad syndrome disorders relating to organic and/or neurological conditions.

The effects of communicative disorders may be prolonged and pervasive. Isolation, academic failure, psychosocial maladjustment, and loss of future earning power may stem from the lack of habilitative opportunities provided early in the affected individual's life.

The term speech and language impairment includes disorder in one or a combination of the following parameters: articulation, voice, fluency, and expressive or receptive language.

A. *Articulation Disorders*

Impairment in articulation refers to defective production of speech sounds which interferes with ready intelligibility of speech. Both the type and number of misarticulations contribute to the effect upon intelligibility. The four types of articulation error (omission, substitution, distortion, and additions) may occur singly or in combination.

B. *Voice Disorders*

Included in this type of disorder are abnormalities in pitch, loudness, and quality or resonance. A high incidence of medical etiology is associated with such problems. In most cases, anatomical and pathological studies are required to establish the severity of the disorder and the appropriate approach to management. In certain cases, remedial surgery may be far more appropriate and successful than therapeutic management.

Medical evaluation and participation should be an integral part of programming for children with voice disorders.

C. *Fluency Disorders*

Commonly referred to as "stuttering," this disorder signals a disruption in the normal flow of verbal expression to the degree that both speaker and listener evidence negative reactions. All humans vary in their degree of fluency when communicating orally. Pupils will reflect considerable individual reactions to their nonfluencies which may or may not nearly match listener reaction. Adverse listener reaction to relatively minor disfluencies can sometimes create a more severe problem. This disorder can present a vast array of psychosocial problems.

D. *Expressive/Receptive Language Disorders*

Language impairment is defined as a disability in verbal learning resulting in varying degrees of inability to acquire, use, or comprehend spoken, read, or written language in the absence or sense organ impairment.

Disorders associated with expressive language are evidenced in the inability to use verbal symbols. Receptive disorders occur at the level of comprehension. These problems range from non-verbal (a total inability to express or process thoughts and ideas with words) to a mild disruption in syntax and sporadic inattentiveness. Language problems can reflect subtle and sometimes serious underlying problems, such as central auditory processing deficits, minimal cerebral dysfunction, and psychosocial instability.

The etiology of any of these disorders may be in the realms of organic, neurologic, psychologic, developmental, learning, or experiential factors, singly or in combination. High-incidence causative factors include deficits in motor integration, cerebral dysfunction, learning deficits, and developmental lag.

SECTION II. THE EDUCATIONAL CHALLENGE

Communicative impairment is the inclusive term used to denote the continuum of communicative problems and needs found in students requiring language and speech services.

A. Pupils with communicative *disorders* are those exhibiting severely impaired language, voice, fluency, articulating, or hearing to such degree that academic achievement and/or psychosocial adjustment is invariably affected and the condition is significantly handicapping.

B. Pupils with communicative *deviations* include those with mild developmental problems in language, voice, fluency, or articulation, as well as those with mild hearing loss. The milder degree of severity does not, however, contraindicate the need for interventional measures in order to permit these students to perform satisfactorily in the educational setting. The frequency and nature of such measures, however, may be programmed at a different level than for those students with more severe impairment.

C. Students with communicative *delay* include the general school population for whom organized sequenced curricular activities should be provided to promote the development of adequate communicative skills that will be beneficial to them as part of their overall educational program. Delay does not necessarily imply a handicapping condition, but is dependent upon the nature, extent, and degree of lag.

D. Multiple-handicapped students include those with a complex of conditions requiring special educational services designed to ameliorate the effects of their combined impairments. When communicative disorders are present and contribute to the student's total disability, the provision of language, speech, or hearing services is essential.

For each child or youth, a comprehensive, individualized program must be delineated to meet the mild to profound developmental/educational problems which are encountered in the speech/language impaired population. The implementation of such a program will require the development of a hierarchy of communicative skills which include the following abilities:

- To utilize and integrate the full range of vegetative functions upon which speech is overlaid (breath control, deglutination, palatal function, refined labial and lingual movements) ;
- To control phonation;
- To identify and discriminate environmental and speech sounds;
- To produce speech sounds with sufficient rapidity to produce intelligible speech;
- To utilize receptive and expressive skills in communication;
- To adapt to alternate means of communication when speech is not feasible;
- To follow directions;
- To develop positive communicative attitudes.

Whatever the degrees of impairment, the student must be helped to achieve the communication level that is maximum to his own highly individualistic set of circumstances—symptomatic, intellectual, and social.

SECTION III. BASES FOR PLACEMENT

All communication disabilities occur somewhere on a continuum from minor developmental delays to disorders that demand intensive intervention. Determining the severity of communication disorders is not always the sole responsibility of the speech and language specialist, although in most instances such is the case by virtue of the unique training and experience of the specialist. In some instances disorders in this area are a manifestation of underlying medical problems which require medical diagnosis and intervention. Many other disorders are attendant to obvious or more subtle dehabilitating conditions. In either event, a multidisciplinary assessment is required to arrive at an adequate diagnostic/prognostic model and appropriate service planning. The appraisal of a speech/language problem in and of itself does not necessarily imply the need for direct remedial services of speech/language personnel, although such personnel must coordinate diagnosis and instruction in this area.

Establishment of pupil eligibility for various program delivery services should include consideration of factors in two broad areas:

- the severity of the pupil's communication problems in terms of any present and future personal, social, and educational handicaps;
- the likelihood that these handicaps will diminish with the kinds of services that can be made available.

A. *Specialized Interdisciplinary Systems—Statewide/Regional Special Schools and Facilities, Intensive Learning Centers, Institutional Settings*

Placement in a more restrictive alternative must be considered when the intensity and complexity of the handicapping conditions require the total commitment of a multidisciplinary staff that will afford coordinated daily intervention to each aspect of the disorder syndrome. Placement at this level is rarely decided upon the basis of speech or language impairment alone, except in such low incidence cases as severe developmental aphasia or massive central auditory dysfunction.

For these severely impaired students, the educational environment which is most fully supportive, most closely matched to their specialized needs, and most effective in maximizing the usage of compensatory skills while more conventional skills are being developed, becomes in practice "the least restrictive environment," regardless of its geographic or placement designation.

Any child whose diagnosis confirms a profound speech/language impairment, whether it exists of itself or as a concomitant to a multiple handicapping condition, should be initially placed in a facility providing full-scope intervention.

B. *Mainstream Continuum of Services (with Multidisciplinary Support)—Regular Classes, Resource Rooms, Special Class Settings*

The preferred system for delivering instruction and special services to most speech and language impaired students is by accommodating them in regular school facilities to provide integration with curriculum opportunities available to nonhandicapped students. It holds, therefore, that the program for these students should be an integral part of the entire instructional system, providing remedial services that will maximize the benefits accrued from their regular/special education programs.

Special Education/Related Services

Each child receiving speech/language services must be identified as in receipt of these services either as special education or as a related service. If a child's *primary* handicap is designated as speech/language impairment, or if the only specially designed instruction required to meet his special needs is speech/language therapy, then the service is special education and the child is placed appropriately along the continuum of services. If a child's primary handicap lies within one of the other nine categories of exceptionality and he is in receipt of speech therapy services, then these services are related services.

Services at this level should include self-contained classes for those who cannot profit from the regular instructional program, resource rooms, direct services, and consultation services available to regular and special class teachers. Whenever necessary, special classes for such low incidence students should be developed among two or more districts utilizing the consortium model.

All school personnel should have a clear understanding of the goals and objectives of programs offered in speech/language habilitation, and of their individual responsibilities in it. It should be the responsibility of the local district to disseminate such information and to develop an integrative approach involving the child, his parents, his classroom teacher, the speech and language specialist, and any other ancillary service personnel. A uniform severity rating should be used throughout the state to serve as a guide in determining placement along the service continuum, to obtain uniform identification of children with communicative disabilities, and to facilitate communication among staff as the child moves between programs or districts.

SECTION IV. THE DELIVERY OF SPECIAL EDUCATION AND RELATED SERVICES

A. *Identification and Diagnosis*

There should be within each district a system for screening, identification, and tracking of all students exhibiting speech/language anomaly at any age. It is recommended that all children entering into the system at the pre-school, kindergarten, or first grade levels be screened, and all pupils not in a speech/language program be screened again at third grade entry level.

Speech and language specialists should endeavor to develop or to acquire a screening instrument which identifies potential problems within a time frame of three minutes per pupil, in order to process efficiently a relatively large target population. Such screening is the sole responsibility of the speech and language specialist, who will, in addition to routine screening, accept referrals from staff on any new students and others in whom are noted problem possibilities.

Children who fail the screening or who are referred by staff should be evaluated by the specialist, using standardized, validated assessment procedures, including a sampling of spontaneous speech taped for later analysis.

Hearing screening designed by an audiologist and administered by properly trained personnel should be conducted at school entry and at regular intervals thereafter. Those children who fail such screening should be reported to the IPRD (identification, placement, review, and dismissal) administrator, who, with the school nurse, will arrange for follow-up testing and for securing parental consent.

The basis for any and all services delivered by the speech and language specialist is professional assessment and diagnosis of pupil communicative behavior. Based on such assessment, a determination can be made utilizing a uniform severity rating scale of the child's status in terms of 1) within normal range or 2) falling into one of the three general categories of impairment (disorder, deviation, or developmental delay).

While it is true that a large number of early anomalies are developmental in nature and need no intervention other than that offered by the structured learning experiences of the classroom or by preventive programming, such students must be tracked and scheduled at a later time as necessary.

B. *The Individualized Education Program (IEP)*

Responsibility for the coordination of the individualized education program (IEP) conference lies with the designated administrator within each district, usually the building principal at the less restrictive levels. In those cases where the child is placed outside his home district, subsequent conferences are the responsibility of regional program administration.

An IEP is to be developed on each handicapped child, regardless of the number or intensity of services he receives. Where speech and language services are the sole intervention component of the handicapped child's curriculum, all the requirements stipulated in P.L. 94-142 and the Delaware Administrative Manual apply. In such a case, the professional and legal requirement could be met by the speech/language specialist, with appropriate administrator and parent involvement.

Where speech/language intervention is a related service, such service is to be delineated within the student's IEP, with the specialist participating in the IEP preparation, and in the meeting where possible. Consideration should be given to the inclusion of the speech/language specialist in the IEP development of the LD child with a language component, even though such remediation may be implemented by other staff, since by virtue of training and experience, the specialist is uniquely qualifed to interpret data and make specific recommendations for program implementation.

C. *Program Structure*

1. *Leadership*

The administration of speech and language programs within the districts is commonly the responsibility of the coordinator of special education, curriculum coordinator, or is under the special services component. The position of Supervisor of Speech and Hearing Services should be considered where the population warrants it. Supervision and program coordination where personnel from the Office of Speech and Hearing, Department of Health and Social Services, are utilized are effectively provided, often on site, by supervisory level speech pathologists from that office.

Emphasis should be placed upon the provision of specific program supervision in the schools to ensure that speech and language services are fully integrated with the program (s) served and to ensure compliance with Federal and State regulations.

State level leadership emanates from the Exceptional Children/Special Programs Division of the Department of Public Instruction, where a strong liaison relationship with district personnel is important in identifying program needs, in providing technical assistance and inservice training, and in delineating problem areas.

2. *Facility Spaces*

Facility requirements will vary with the setting and needs of the population served. On the most restrictive level, where neurophysiologic involvement may be extensive, a barrier-free entry and a room adaptable to the use of wheelchairs and posture maintaining equipment are needed. On the least restrictive level, a room of adequate size for resource purposes or individual therapy should be regularly available to the speech and language specialist, whether permanently assigned or itinerant.

All space should be adequately lighted and ventilated, with several electrical outlets, adequate storage for materials and equipment, and a locked file to preserve student record confidentiality. The room must be private and relatively free of extraneous noise.

3. *Staff Composition*

Minimal standards for staff in the area of speech and language are provided by the certification requirements of the State Department of Public Instruction, and, in the case of contracted services from the Division of Speech and Hearing of the Department of Health and Social Services, by standards prescribed by that agency.

It is recommended, however, that additional course work within the area of their specialization be required of speech and language personnel working within the more restricted levels and for those dealing with severely involved students who may be mainstreamed back into a regular school setting. Specialized training is imperative for personnel involved in habilitation of the deaf and deaf/blind, the severely retarded, the neurophysiologically impaired, and the aphasic.

Discretionary utilization of ancillary services, such as social workers, psychologists, guidance counselors, and outreach coordinators, should be implemented upon the recommendation of the administrator assigned such responsibility, based on unique student needs.

The development and utilization of speech aides and volunteers is strongly encouraged to provide the most cost-efficient support system where learning must become habituated to be useful. Sufficient staff must be available to ensure an adequate level of services. Pupil-to-staff ratios should be based on such factors as the nature and severity of the handicap, the ages and intellectual abilities of pupils, and the availability of personnel for reinforcement activities.

4. *Program Components*

Figure 1. presents in a conceptual outline the components that should be implemented for speech and language impaired children in school programs on a statewide basis. In addition, the following section, "Program Coordination," presents guidelines for placing speech and language impaired students along the continuum of services described in the Delaware Administrative Manual (page 20). Added to the continuum is a "Preventive Level," which accommodates the fact that certain minimal delays which cannot be thought of as handicapping nevertheless deserve attention which is most often handled by the classroom eacher in consultation with the speech and language specialist.

5. *Program Coordination*

A comprehensive service program for speech/language impairments is best grounded in a conceptual framework that accounts for the widest diversity of individual needs and abilities. Central to the full service ideal is the concept that speech and language development is an integral part of the educational process, and, as such, strategies to improve lagging skills in this area belong in the classroom as well as in the therapy room. Within this context, primary level children displaying minor language and articulation delays may be serviced effectively within the small learning group arrangements that are common to most classroom settings. The continuum of services described below encompasses the full range of pupil extremes—from those needing only minor assistance to prevent potential later problems to those for whom a 24-hour treatment environment is required.

Preventive Level	*Regular classroom consultation services* from the speech and language specialist emphasize specific procedural recommendations and whole-class recommendations for speech/language improvement. This service may be considered preventive and should be offered to nonhandicapped children whose minor delays may stem from environmental deficiencies or lack of adequate speech models in their home setting.
Level I	*Regular classroom intervention services* emphasize specific programming for groups where the speech/language function is considered developmentally delayed. Standardized remedial and improvement programs may be recommended and supervised by the specialist and implemented by the classroom teacher, therapy or classroom aides, or volunteers.
Level II	*Direct therapeutic intervention by the specialist provides services to groups of children* identified as unable to profit sufficiently from assistance in the regular classroom. This level may include resource room services and should include supplemental reinforcement administered by aides, volunteers, and/or parents under the direction of the specialist.
Level III	*Direct therapeutic intervention by the specialist provides services to individuals* where significant impairments (disorders) in speech/language interfere importantly with communication. Such children should receive direct, intensive, individual therapy from the specialist, together with other supportive activities to the extent prescribed by the specialist. Such activities might include any of the above programs, along with the reinforcement component to strengthen the impact of individual intervention.
Level IV	*Special classes are provided for children whose impairment is such that major alterations in the total learning environment are required.* Such children may be mainstreamed into physical education, music, and lunch and playground activities, as appropriate. The low incidence of cases displaying such a degree of severity in this area of exceptionality commonly requires interdistrict arrangements to establish such special classes.
Level V	*Special school placement* may be considered for those children for whom the above programs are not sufficient. It shall be the responsibility of the LEA to recommend specific school(s) which will effectively meet the needs of such a child and to follow the required procedures governing such placements.
Level VI	*Supportive instruction at home or hospital* may be considered a temporary alternative to other types of programming when reasons of health or other factors preclude attendance at school.
Level VII	*Residential schools and treatment centers* provide services in cases so rare and/or complex that an appropriate education cannot otherwise be provided.

SECTION V. STAFF PROFESSIONAL GROWTH

A. *General Program Orientations*

Professional inservice training programs should focus in three directions. The first emphasis is training and instruction for the speech and language specialist, who is the professional providing direct therapeutic services. The next effort should be directed to the regular and special education classroom teacher. The student receives his primary instruction in the classroom, and it is imperative that the level, type, and manner of instruction be complementary with therapeutic services. The third, and perhaps the most important effort, should be directed toward the parents. The child spends the major portion of the day with his family who, in fact know him best. Often a family will require considerable counseling in order to deal with the child's special needs. It cannot be stressed enough that the parents and other family members be provided with counseling and training to assist them in dealing with the child.

B. *Specific Program Implementations*

It is advised that speech and language specialists attend a workshop twice a year dealing with current research in the area of speech and language pathology. Such workshops/courses could be jointly sponsored by the Delaware Department of Public Instruction, the Delaware Speech and Hearing Association, and the Office of Speech and Hearing of the Department of Health and Social Services.

In regard to programs for the regular and special education classroom teacher, it is advised that the speech and language specialist in each local school district be responsible for presenting inservice programs designed to meet the specific needs of the school district personnel. Some suggested topics include: definition of speech and/or language impairment, nature of the exceptionality, types of impairment (to include sample case studies), level of academic placement indicated by the impairment, suggestions of current literature, and materials workshops. The specialist may also consider inviting experts in the field to speak to this group.

Parent counseling and training may be initiated by the speech and language specialist at the time when therapeutic intervention begins. This is an on-going process to insure that parental involvement is continuous. The parents may be encouraged to attend several therapy sessions, directed toward current literature and research, invited to staff workshops dealing with speech and language impairment, or encouraged to join a parents advisory council. They must be an integral part of the educational program if their child is to be successful.

SECTION VI. REFERENCES

Baldes, Robert A. et al. *Iowa's Severity Rating Scale for Communication Disabilities.* Department of Public Instruction, Special Education Division, Des Moines, Iowa, 1978.

Bloodstein, Oliver. *A Handbook on Stuttering.* Easter Seal Society Press, Chicago, Illinois, 1975.

Brutten, Eugene J. and Donald J. Shoemaker. *The Modification of Stuttering.* Prentice-Hall, Inc., Englewood Cliffs, New Jersey, 1967.

Goldenson, Robert M. *Disability and Rehabilitation Handbook.* McGraw-Hill Book Co., New York, New York, 1978.

Healey, William C. and Kenneth O. Johnson. *Standards and Guidelines for Comprehensive Language, Speech and Hearing Programs in the Schools.* The American speech and Hearing Association, Rockville, Maryland, 1973-74.

Jones, Shirley A. and William C. Healey. *Project Upgrade, Model Regulations for School Language, Speech and Hearing Programs and Services.* The American Speech and Hearing Association, Rockville, Maryland, 1973.

Muma, John R. *Language, Assessment and Intervention.* Prentice-Hall, Inc., Englewood Cliffs, New Jersey, 1976.

Perkins, William H. *Speech Pathology.* C. V. Mosby, Co., St. Louis, Missouri, 1977.

Schiefelbusch, Richard and Lyle L. Lloyd. *Language Perspectives, Acquisition, Retardation and Intervention.* University Park Press, Baltimore, Muryland, 1974.

State-Federal Information Clearinghouse for Exceptional Children. *Digest of State Laws and Regulations for School Language Speech and Hearing Programs.* The American Speech and Hearing Association, Rockville, Maryland, 1973.

Travis, Lee Edward. *Handbook of Speech Pathology.* Appleton-Century-Crofts, Inc., New York, 1957.

Van Riper, Charles. *Speech Correction.* Prentice-Hall, Inc., Englewood Cliffs, New Jersey, 1967.

SECTION VII. GLOSSARY

addition. A type of articulatory defect in which extra phonemes are improperly added to the word.

allophone. One of two or more variants of the same phoneme.

articulation. The production of individual sounds in connected discourse; the movement and placement during speech of the organs which serve to interrupt or modify the air stream into sounds.

audiologist. An individual who holds a degree and certification or license in audiology and whose specific interest is in the identification and measurements of hearing loss and in the rehabilitation of those persons with hearing impairment. In addition, the individual provides consultation, instruction, and evaluation.

auditory discrimination deficit. An inability to distinguish among various speech sounds.

cerebral palsy. A defect of motor power and coordination related to damage of the brain.

childhood aphasia. An impairment or absence of communication by speech, writing, or signs due to dysfunction of brain centers in the dominant hemisphere of a child.

delay in language acquisition. A marked delay in the expected process of knowledge and usage.

distortion. In articulation, the correct phoneme is approximated but the allophone is not close enough to be normally acceptable.

fluency. The flow of verbal expression that is considered acceptable by most listeners.

labial. Pertaining to the lips.

lingual. Pertaining to the tongue.

morpheme. The smallest meaningful unit of a language.

neurological impairment. An impairment of the nervous system.

omission. An articulation disorder in which phonemes included in normal pronunciation are absent.

organ impairment. An impairment of any body organ/part.

phoneme. The smallest distinguishable unit in a given language – a family of sounds.

pitch. Perception of highness or lowness of a sound, determined by fundamental frequency.

resonance. The vibratory response of a body or air-filled cavity to a sound or a frequency imposed on it.

speech. Medium of oral communication that employs a linguistic code (language); through this medium one can express thoughts and feelings and understand those of others who employ the same code.

speech and language specialist. An individual with a degree and/or certification in speech and language pathology who is qualifed to diagnose speech, language, and voice disorders and to prescribe and implement therapeutic measures. In addition, the individual provides consultation, instruction, and evaluation.

substitution. An articulatory disorder in which incorrect phonemes are substituted for those that would normally be heard.

syntactic problem. A difficulty with the arrangement of words of a sentence in grammatical form.

voice. Sound produced primarily by the vibration of the vocal folds.

STATE OF DELAWARE GENERAL GUIDELINES FOR THE DEVELOPMENT OF PROGRAMS OF SPECIAL EDUCATION AND RELATED SERVICES FOR CHILDREN AND YOUTH WITH HEARING IMPAIRMENTS

The Delaware Department of Public Instruction

William B. Keene, *State Superintendent*
John J. Ryan, *Acting Deputy State Superintendent*
Assistant State Superintendent
Administrative Services Branch
Randall L. Broyles, *Assistant State Superintendent*
Instructional Services Branch

V

STATE OF DELAWARE GENERAL GUIDELINES FOR THE DEVELOPMENT OF PROGRAMS OF SPECIAL EDUCATION AND RELATED SERVICES FOR CHILDREN AND YOUTH WITH HEARING IMPAIRMENTS

The Delaware Department of Public Instruction

William B. Keene, *State Superintendent*
John J. Ryan, *Acting Deputy State Superintendent*
    Assistant State Superintendent
    Administrative Services Branch
Randall L. Broyles, *Assistant State Superintendent*
    Instructional Services Branch

The State of Delaware is an equal opportunity employer and does not discriminate or deny services on the basis of race, color, national origin, sex, handicap, and/or age.

Guideline Contributors:

Helen M. Holleger, State Supervisor, Early Childhood and Primary Education, Department of Public Instruction (Guidelines Task Force Chairperson)

Polly Heckler, Clinical Audiologist, Division of Public Health, Speech and Hearing Services

Doin Hicks, Vice President, Division of Research, Gallaudet College

Dolores Pittelli, State Specialist, Delaware Direction Service Center, Department of Public Instruction

Diane A. Synder, Supervisor, New Castle County, Division of Public Health, Speech and Hearing Services

F. Eugene Thomure, Director, Margaret S. Sterck School for Hearing Impaired

Elizabeth Walker, Intermediate Teacher, Margaret S. Sterck School for Hearing Impaired

DEFINITION

Hearing Impairment — An impairment within the auditory system which may interfere with, or preclude, the ability to consistently and appropriately interpret spoken language through audition. A child may be considered for a hearing impaired instructional unit if the auditory impairment hinders educational progress in a regular educational program.

(From Section III, G. 2. of the Delaware *Administrative Manual for Programs for Exceptional Children*).

SECTION I. NATURE OF THE EXCEPTIONALITY

The term *"hearing impaired"* encompasses a range of handicapping conditions from mild to profound. This continuum includes the hard of hearing and the deaf.

The hard of hearing, in general, are those, who, with the use of a hearing aid, have residual hearing sufficient to enable successful processing of linguistic information through audition. Many such persons need special education (and related services) because of their imperfections in language development and because of their limitations in learning communication skills such as speech, reading, and writing.

The deaf are those whose hearing disability precludes successful processing of linguistic information through audition with or without a hearing aid. Such disability is an invisible handicap. There is no outward manifestation of its presence – nothing in appearance identifies the individual as being deaf. It is physical, yet in most instances, is not physically debilitating. Largely, it isolates. It prevents people from achieving the ability to acquire language and to communicate.

Early severe deafness precludes normal language development. Without language, insurmountable barriers to learning and to communication are present and pervasive.

The nature of these handicapping conditions is such that the severity of the impairment is influenced by whether the hearing loss occurs before or after the acquisition of language. Other conditions that influence the nature of the hearing impairment include the extent and configuration of the hearing loss, auding ability (use of residual hearing), the nature and extent of speech and language development, potential for learning, the nature and amount of stimulation at home, and secondary handicapping conditions.

Based on experience, the incidence of hearing impaired persons in relation to the total school population is estimated to fall in the general area of two per one thousand.

SECTION II. THE EDUCATIONAL CHALLENGE

A comprehensive program of habilitation/rehabilitation must be implemented, as appropriate, in each case to meet the mild to profound developmental-educational problems which are commonly encountered among hearing impaired persons. Such problems include interferences with the normal functions of communication, cognition, and psychosocial development in the following areas:

- the ability to use residual hearing;
- the ability to identify and discriminate environmental and speech sounds;
- the ability to respond efficiently;
- the ability to use receptive and expressive skills of communication, i.e., speech, speech reading, manual communications, reading and writing;
- the ability to function with confidence and independence;
- the ability to work independently;
- the ability to follow directions;
- the ability to develop adequate social and emotional maturity;
- the ability to cope with developmental delays in listening, speaking, gesturing, reading, writing and making computations;
- the ability to organize and use information beyond the immediate concrete level;
- the ability to develop vocational interests and skills;
- the ability to adapt to change in the environment;
- the ability to be responsible for hearing aid care and maintenance;
- the ability to utilize senses other than hearing in the learning process.

The potential for habilitation/rehabilitation for each child is strongly related to the educational placement and the instructional plan recommended.

SECTION III. BASES FOR PLACEMENT

A. *Hearing Impaired and Least Restrictive Environment*

For the hearing impaired child to overcome the language barrier and the attendant bond of social isolation, educational intervention of the highest order is required.

The least restrictive environment for a deaf child is one in which language learning opportunities abound; one in which communication flows freely and continuously; and one in which the child is helped to feel confident in his own self worth and esteem.

It is not enough to describe the environment in terms of proximity to home or amount of time spent with hearing peers. It is only the removal of barriers to language and communication which relaxes the restrictiveness of the deaf child's environment and brings meaning to the silent voices about him.

The Conference of Executives of American Schools for the Deaf has published a statement on Least Restrictive Environment. Four major considerations are suggested as criteria for priorities for alternative placement. These may be summarized as follows: 1) those which enable fulfillment of academic and social potential and prepare them for a productive, well-adjusted adulthood, 2) those which permit mobility, offering a succession or combination of placements, 3) those which offer viable alternatives both to students and parents, and 4) those which offer a full service component of all necessary instructional and support services.

B. *Placement*

Placement for a hearing impaired individual cannot be determined simply by the degree of hearing loss. That is, persons with mild or moderate losses may frequently need more than a regular school placement, while some with severe and profound losses may indeed be capable of regular school settings.

The continuum of services provided for in the Delaware *Administrative Manual for Programs for Exceptional Children,* October, 1977, insures an adequate range of options. It should be emphasized, however, that this continuum is not to be construed as hierarchial or judgmental as to the value or related restrictiveness of any one environment.

Clinical data can provide a useful gauge to the probability of placement. However, in the case of hearing impairment (and other low incidence handicapped groups), each situation is extremely individual and requires an observation of the functional capabilities of the child which may vary from any predictability quotient based on a quantitative assessment of severity.

It should be noted that recent research indicates that few hearing impaired children with hearing losses of 70 decibels (dB) or more (in the better ear) presently are now successfully mainstreamed (fully or partially) in academic areas, especially those students whose hearing loss is prelingual in nature.

Children with hearing losses of less than 35 dB may be candidates for supportive services by a speech and language specialist. Such children should be identified and followed closely, but generally do not need specialized intervention within the classroom.

Table I can serve as a useful guide in predicting the potential placement of hearing impaired individuals. This table is adapted by the special study team for this Guideline from one presented by Dr. Robert Frisina in: *A Continuum of Services for the Hearing Impaired of New York State.*

Table 1

Hearing Threshold Levels	Probable Impact on Communication and Language	Present-Day Implications for Educational Settings	
		Type of Mainstreaming*	Probable Need
Level 1, 35-54 dB	Mild	Full	Many
		Partial	Some
		Self-Contained	Few
Level II, 55-69 dB	Moderate	Full	Some
		Partial	Many
		Self-Contained	Few
Level III, 70-89 dB	Severe	Full	Few
		Partial	Some
		Self-Contained	Many
Level IV, 90 dB and above	Profound	Full	Few
		Partial	Some
		Self-Contained	Many

*_Full mainstreaming_ means total mainstreaming into regular school classes for hearing students, with provisions for special services. Normally, this will be accomplished at the district level in the regular school, but may be provided as part of the program at the Sterck School for the Hearing Impaired, _especially at Levels III and IV_. _Partial mainstreaming_ means attending some regular school classes and some self-contained classes. This may be accomplished at the district level in the regular school setting, or may be provided _as part of the Sterck program, especially at Levels III and IV_. _Self-contained_ means attending classes exclusively with other hearing impaired youngsters. Normally, this will be accomplished at the Sterck School, but may be provided in the district regular school setting when feasible.

SECTION IV. THE DELIVERY OF SPECIAL EDUCATION AND RELATED SERVICES

A. *Identification, Diagnosis, and Individualized Education Programs*

The major responsibility for facilitating the identification and diagnosis of hearing impaired children is that of the local school districts. Prior to school age, it is the responsibility of the Division of Public Health, as one of its functions, to facilitate the identification of all handicapping conditions. At and beyond school age, it becomes the responsibility of the local districts to administer screening programs, including hearings, and to initiate further identification and diagnostic procedures for students whose initial screening indicates a possible problem.

Current practice for school age children who fail initial hearing screening is a referral to, upon completion of parent consent forms, to the Division of Public Health, Hearing Conservation Program diagnostic audiologic and otologic clinics, or to family physicians and/or private otologists. (Private otologists, pediatricians, and family practitioners will, in most instances, refer screening failures to Division clinics for further study.) The Hearing Conservation Program, upon completion of these studies, forwards reports to the child's school district. School nurses may also refer screening failures for audiologic study directly to Division audiologists. At present, diagnostic and follow-up audiologic services are provided from birth to 21 years at two clinic sites in New Castle County, two in Kent County, and one in Sussex County. Audiologic and otologic clinic service consists of four clinics per month in New Castle County, two per month in Kent, and two per month in Sussex. Both the State Committee on Hearing Impaired and the Sterck School Coordinator for Off-Campus Services (See B below) will provide facilitative supportive services in the identification and diagnostic process. Similarly, the Division of Public Health provides speech and hearing services throughout the State.

An individualized education program (IEP) plan for each child receiving special education services is mandated by Federal law and State regulations which specify participants, timing, contact, and coordination. Requirements for the development of the initial plans state that one person on the IEP team must be knowledgeable about and able to interpret assessment data. Thus, it is imperative that a person with specific program competence in this area of handicap be a member of the IEP team for hearing impaired individuals.

B. *Program Structure*

1. *Leadership*

The basic leadership role in the education of hearing impaired children, from infancy through 21 years of age, is assumed by the Sterck School and the State Committee on Hearing Impaired (Section IV. E. *Administrative Manual for Programs for Exceptional Children)*. The Committee consists of the following persons: Sterck School Director (Chairperson), Principal, Audiologist, and Psychologists; representative(s) of Public Health, Office of Speech and Hearing; State Supervisor of Exceptional Children Programs, Special School Programs, and the local educational agency representative (generally selected by the district's special education supervisor) appropriate to the committee's concern. In addition, other persons may be invited to scheduled meetings.

The major responsibility of the Committee is to review the status of all identified hearing impaired children in Delaware and to make such recommendations as may be necessary for their habilitation compensation.

Accordingly, the State Committee on Hearing Impaired makes recommendations for the management of the State's hearing impaired population and approves provisions for service units in the various districts throughout the State. To facilitate the Committee's work, the Sterck School Coordinator of Off-Campus Services is responsible for meeting with district personnel and assisting the IEP planning team for all hearing impaired children in the State. The coordinator will meet also with the Committee at scheduled and special meetings. In addition, the coordinator will work closely with the Division of Public Health in screening and identification procedures.

It is the responsibility of the district to collect the data necessary for the Committee's deliberations, to send appropriate representatives to the committee meetings, and to conduct the IEP meetings for the initial placement. Annual reviews need to be conducted by the district for those children remaining in the district program. For those students at the Sterck School, annual review and subsequent placement are the responsibility of Sterck personnel. In all cases, it is anticipated that the recommendation of the Committee on Hearing Impaired will be a major aspect of program planning.

2. *Facility Spaces*

Unless secondary physical handicaps are present, hearing impaired students do not require major facility modifications related to access and mobility. Other important considerations are necessary, however.
These include:

- extensive acoustical treatment of instructional areas to reduce extraneous noise which would interfere with amplification equipment or otherwise be distracting. Such treatment includes carpeting as well as sound absorbing wall and ceiling materials;
- a high level of non-glare lighting, evenly diffused;
- provision for group and/or individual high fidelity amplification equipment;
- adequate electrical service for use of extensive electronic media;
- provision for a visual alarm system in all building areas frequented by hearing impaired students (including restrooms).

Other specialized facilities and adaptations for hearing impaired persons are incorporated into the Sterck School physical plant, but are not discussed here.

Information regarding specialized facility requirements for all handicapped persons is available from the National Center for a Barrier Free Environment, which is located on the Gallaudet College Campus, Washington, D.C. 20002. The physical plant department at Gallaudet College also provides specific information and consultative assistance related to facility requirements for hearing impaired persons.

3. *Staff Composition*

Specific provision must be made for an adequate level of services as determined by the IEP planning team in each of the following areas:

- special education teachers and aides for the hearing impaired individual;
- specialists, such as reading, resource and learning disabilities specialists;
- speech pathologists; (speech and language specialists);
- audiologist;
- physical and occupational therapist;
- otologist;
- social worker;
- psychologist;
- guidance counselor;
- parent-child specialist;
- outreach case coordinator;
- interpreter-tutor.

The above list of service providers is not exhaustive. The teacher, of course, is the key person in any educational setting. The relative prominence of any role, however, is determined by the nature and severity of the handicap which, in turn, suggests management strategies.

Frequently, handicaps are multiple in nature. This multiplicity, the relative debilitating effects, and many other individual considerations become paramount in educational planning. Above all, the educational enterprise should be a team effort. The composition of the team and the relative roles of its members will change as services are phased in and out during the child's growth and development. Specialists providing services may be from other agencies, such as the Division of Public Health. It is important for the school administrator to communicate with and include such specialists in the IEP planning and review meetings.

4. *Parent Programs*

The success of the child is dependent upon the level of parent involvement in programs designed to bring parents and professionals together on a regular basis. The main purpose is to provide instruction, guidance, and support, in addition to offering an opportunity to exchange and share information and experience. In turn, the parents' group has a responsibility to support and participate in programs that are of mutual benefit to the parent, child, and school. An important outgrowth of parent activity lies in the realm of advocacy. Parents can provide input to policy-making groups to secure additional supportive services, to support on-going and innovative programs, and to secure access to pertinent in-service training offerings.

SECTION V. STAFF PROFESSIONAL GROWTH

The provision for educational and related services to Delaware's hearing impaired youth is unique. The Margaret S. Sterck School for the Hearing Impaired is administered within a local district but has statewide responsibility for service delivery. It receives support from the State to carry out this broad program. It is, therefore, a local, regional, and state agency all in one. Delaware's size and organizational pattern for education makes this practical. The plan is economical, efficient, and already has demonstrated its efficacy as a model for other small states and regions within larger states.

A professional growth plan for staff, likewise, can be a coordinated statewide enterprise with Sterck School providing the leadership. The plan is based on strategies utilized by professionals in other areas of handicap and is a continuum, but one with hierarchical characteristics. That is, the program moves from training of a general, orientation nature to more sophisticated, in-depth activities. In relating the program content to an implementation plan, it is useful to consider the seven-phase continuum outlined in the Delaware *Administrative Manual for Programs for Exceptional Children*. A basic assumption is that professionals working in program levels one – three would receive professional growth opportunities of a more general nature, as outlined in areas one – three below. Those professionals working in continuum programs four – seven would receive professional growth opportunities of a more comprehensive nature, including areas four – six below. There is, however, one potential fallacy in this kind of differentiation and, thus, a caution should be observed. There is some logic to considering the severity of handicap as a guide to the nature of inservice training provided professionals. That is, some severely handicapped students will be placed in continuum levels one – three programs and such students may be quite successful in those placements. The professionals who work with them, however, may need inservice training of a more sophisticated level than if they worked only with those students who have mild or moderate handicaps. Accordingly, professional growth must be considered an individual matter. Determination of implementation then must take into account the individual's background and training as well as the severity and nature of handicaps served by that individual. To the extent that these factors do not fit placement continua or other conventional models and matrices, adjustments in inservice training delivery must be made.

A. *Sterck School for the Hearing Impaired Programs*

1. *General Program Orientations*

The Sterck School (including its mainstream program, preschool program in Kent and Sussex Counties, and other outreach components) should provide information annually to the total staff regarding current, pertinent Federal, State, and local regulations, policies, and priorities.

Provision should be made annually for communication about various program components of the Sterck School to the staff so that all personnel are aware of the total program and their relationship to it.

2. *Specific Program Implementations*

Provision should be made annually for the involvement of appropriate staff members in the implementation, review, and modification or renewal of the major program components of the Sterck School. Arrangements should be made for the continued briefings and staff interactions essential to the effective development of Individualized Education Programs (IEPs) for the Sterck School student population.

3. *Topical Presentations*

   Periodic presentations by key personnel who have participated in recent statewide inservice programs should be provided to augment the knowledge base of the total Sterck School staff. Such presentations should include information from interdisciplinary inservice programs which is relevant to the needs of Sterck School students.

4. *Model Case Studies*

   Visits by interdisciplinary national specialists to provide in-depth studies of selected model cases should be scheduled.

5. *Professional Practica*

   Selected annual participation by key leadership specialists desiring clinical practicum experience should be scheduled. Such experiences can be mutually beneficial to the specialists and the Sterck School.

6. *Product Workshops*

   Special inservice institutes to develop particular assessment or program materials should be conducted as necessary.

B. *District Level Programs*

1. *General Program Orientations*

   Vital information and concise orientations must be provided by the Sterck School and the State Committee on the Hearing Impaired to districts with units for hearing impaired children.

2. *Specific Programs Implementations*

   Assistance must be provided by the Sterck School and the State Committee on Hearing Impaired to district level personnel regarding the development of Individualized Education Programs (IEPs) for each hearing impaired child/youth in the program.

3. *Topical Professional Presentations*

   Selective attendance at pertinent topical presentations should be encouraged for district personnel involved in the education of hearing impaired students. Sterck School personnel and the State Committee on the Hearing Impaired should take the initiative in promoting such involvement.

SECTION VI. REFERENCES.

Babbini, Barbara. Manual Communication. U. of Illinois, 1974. Christopher, Dean. Manual Communication: A Basic Text. University Park, 1976.

Behre, Solano, and Feulner. Continuum of Services for the Hearing Impaired Children of New York State. Report of the New York State Conference. 1975.

Berg and Fletcher, ed. The Hard of Hearing Child: Clinical and Educational Management. Grune and Stratton. 1970

Bolton, Brian, ed. Psychology of Deafness for Rehabilitation Counselors. University Park Press, 1976.

Brasel and Quigley. The Influence of Early Language of Communication Environments on the Development of Language in Deaf Children. University of Illinois. 1975.

Brill, Richard. The Education of the Deaf. Gallaudet, 1974.

Calvert and Silverman. Speech and Deafness. A.G. Bell, 1975.

Frisina, Robert, ed. A Bicentennial Monograph on Hearing Impairment Trends in the U.S.A. AGB, 1976.

Furth, Hans. Deafness and Learning: A Psycho-Social Approach. Wadsworth Press, 1973.

Gregory, Susan. The Deaf Child and His Family. Halsted, 1976.

Katz, Mathis, and Merrill. The Deaf Child in the Public Schools. Interstate, 1974.

Levine, Edna. Lisa and Her Soundless World. Human Services Press, 1974.

Ling, Daniel. Speech and the Hearing Impaired Child: Theory and Practice. AG. Bell, 1976.

Madson, Willard. Conversational Sign Language. Gallaudet, 1972.

Mindel and Vernon. They Grow in Silence: The Deaf Child and His Family. NAD, 1971.

Nicolosi, Harryman, and Kresheck. Terminology of Communication Disorders, Speech, Language, Hearing. Williams and Wilkins Company, 1978.

Northcott, Winifred, ed. The Hearing Impaired Child in a Regular Classroom. A.G. Bell, 1973.

Reynolds and Birch. Teaching Exceptional Children in All America's Schools. The Council for Exceptional Children, 1977.

SECTION VI. REFERENCES, continued

Russell, Quigley, and Power. *Linguistics and the Deaf Child*. A.G. Bell, 1976.

Schlesinger and Meadows. *Sound and Sign: Childhood Deafness and Mental Health*. University of California Press, 1972.

The Changing Role of School Programs for Deaf Children: Selected Papers. The Conference of Executives of American Schools for the Deaf, Inc., 1977.

SECTION VII. GLOSSARY.

auding. Integrative function involving the reception and comprehension of of acoustic information.

audiologist. An individual who holds a degree and certification or license in audiology, and whose specific interest is in the identification and measurement of hearing loss and rehabilitation of those with hearing impairments. In addition, the individual provides consultation, instruction and evaluation.

audition. The sense or act of hearing.

decibel (dB). A quantitative unity of sound intensity.

language. Symbolic formulation, vocal or graphic, of ideas according to semantic and grammatical rules for communication of thoughts and feelings.

linguistic. Of or pertaining to language.

otologist. A physician specializing in the study, diagnosis and treatment of of diseases of the ear and related structures.

outreach case coordinator. The individual responsible for coordinating off-campus services and who acts as a parent liaison.

parent-child specialist. The person who provides the parents with guidance and instruction for assisting infants and preschoolers to develop appropriate cognitive and communicative behaviors and skills.

postlingual deafness. Deafness occurring at an age following the spontaneous acquisition of speech and language.

prelingual deafness. Deafness present at birth, or occurring early in life at an age prior to the emergence of speech or language.

resource specialist. A permanent or itinerant individual who provides intermittent supportive services (on a regular basis) for individuals or groups of pupils.

speech. Medium of oral communication that employs a linguistic code (language); through this medium one can express thoughts and feelings and understand those of others who employ the same code.

speech and language specialist. An individual with a degree and/or certification in speech and language pathology who is qualified to diagnose speech, language, and voice disorders and to prescribe and implement therapeutic measures. In addition, the individual provides consultation, instruction and evaluation.

STATE OF DELAWARE
GENERAL GUIDELINES FOR THE DEVELOPMENT OF PROGRAMS OF SPECIAL EDUCATION AND RELATED SERVICES FOR CHILDREN AND YOUTH WITH SPECIFIC VISUAL IMPAIRMENTS

The Delaware Department of Public Instruction

William B. Keene, *State Superintendent*
John J. Ryan, *Acting Deputy State Superintendent*
Assistant State Superintendent
Administrative Services Branch
Randall L. Broyles, *Assistant State Superintendent*
Instructional Services Branch

STATE OF DELAWARE GENERAL GUIDELINES FOR THE DEVELOPMENT OF PROGRAMS OF SPECIAL EDUCATION AND RELATED SERVICES FOR CHILDREN AND YOUTH WITH SPECIFIC VISUAL IMPAIRMENTS

The Delaware Department of Public Instruction

William B. Keene, *State Superintendent*
John J. Ryan, *Acting Deputy State Superintendent*
Assistant State Superintendent
Administrative Services Branch
Randall L. Broyles, *Assistant State Superintendent*
Instructional Services Branch

The State of Delaware is an equal opportunity employer and does not discriminate or deny services on the basis of race, color, national origin, sex, handicap, and/or age.

Guideline Contributors:

Richard L. Connell, State Supervisor, Exceptional Children Programs, Department of Public Instruction, (Guideline Task Force Chairperson)

Richard W. Dalton, Supervisor, Programs for the Visually Impaired, Bucks County Intermediate Unit,b doylestown, Pennsylvania

Pauline Still, Resource Room Teacher for Visually Impaired, Area I, New Castle County School District

J. Lynne Young, Director of Educational Services, Division for the Visually Impaired, Department of Health and Social Services

DEFINITION:

Visual Impairment – The child's sensory visual impairment is such that he or she cannot develop his educational potential without special services and materials.

a. A blind child is one who has a visual acuity of 20/200 or less in the better eye with best correction, or a peripheral field so contracted that the widest diameter of such field subtends an angular distance no greater than 20 degrees as determined by an ophthalmologist or optometrist.

b. A partially sighted child is one who has a visual acuity between 20/70 and 20/200 in the better eye with best correction, or who has a disease of the eye or body that seriously affects vision as determined by an ophthalmologist or optometrist.

(Section III. G. 1. of the Delaware *Administrative Manual for Programs for Exeptional Children.*)

SECTION I. NATURE OF EXCEPTIONALITY

A visually impaired child would be one who is between the ages of 0-21, whose visual impairment ranges from mild to severe, and who may or may not have secondary handicapping conditions.

Educationally, visually impaired children can be divided into those children who will receive most of their education visually and those children who will have to learn by way of auditory or tactual materials. A child whose visual problem is primarily perceptual would not fall under the definition of visual impairment, but could fall, for example, under the classification of learning disabilities. On the other hand, a child who is visually impaired may also have a developmental problem. Such a child will require services appropriate to each area.

Functionally, a visually impaired child may require a great deal of specialized materials, training, and equipment, or he may function very well with only a few minor adaptions, such as increased lighting or large print books. Visual acuity, however, is not the only function to be considered in determining the degree of handicap or the nature of services required. The relationship of the visual handicap to the functioning of the whole child must be considered.

SECTON II. THE EDUCATIONAL CHALLENGE

The educational challenge presented by the visually impaired child is primarily that of 1) adapting the environment so that the child can learn, and 2) teaching certain children the necessary skills, such as Braille, mobility, daily living skills, and *optacon*.

A. Adaptions to the environment can include such things as:

- Change in lighting, either to increase contrast or reduce glare;
- Materials adaptations, such as photocopying a ditto, changing the color of the chalk used by the teacher, putting a book or other curriculum materials into large print or Braille, or introducing a low vision aid (magnifier, etc.) or closed circuit TV system;
- Classroom or school modification, such as changing a child's seating in the classroom, increasing the lighting in a hallway or stairwell, or providing a buddy system with the child's classmates;
- Specialized equipment, such as Braille writers, typewriters, *optacons*, cassette recorders, or *sonic-guides* and talking books.

B. Skills and training which many visually impaired children need in addition to environmental adaptions include:

- orientation/mobility training;
- Braille;
- *optacon;*
- typing;
- auditory training;
- daily living skills;
- visual efficiency;
- operation of specialized equipment;
- independency;
- handwriting;
- career training;
- training in the use of low vision aids.

The unique features of Delaware's response to the educational challenge presented by the visually impaired child are:

- the planned intent to develop and maximize the independent capacity of the students as quickly as possible; and
- the statewide interagency nature of the program.

The total statewide program provides for resource rooms strategically located throughout the State, i.e., at least one per county, and a staff of teacher consultants providing direct service to teachers and students in whatever educational setting has been deemed most appropriate for the person involved. Under the direction of the Division for the Visually Impaired, the coordinated statewide effort aims to ensure that success is not measured by the amount of time the student spends in the program, but by the ability of the resource room teachers and the itinerant staff to train the students to overcome their handicaps and become independent.

Of all handicapped persons, those with visual impairments have one of the greatest potentials for rehabilitation. Partially sighted students and even totally blind students can learn to adjust and adapt to the mainstream of society. Provided proper training is given to the student, visual impairment alone should not impede normal educational development. Accordingly, the majority of visually impaired students are enrolled in the itinerant programs, rather than in resource rooms or residential schools.

By providing a resource room program at the critical early period of a visually impaired child's life and/or by providing supportive services to aid the student and the classroom teacher in educating the visually impaired student, such students are able to be maintained in the educational setting most appropriate to their total educational needs, whether in a preschool, in a special school or institution, or in a regular classroom.

SECTION III. BASES FOR PLACEMENT

A visually impaired child is placed in an educational setting according to many variables and as a result of a review of diagnostic data by a multidisciplinary team. The factors include, but are not limited to, the degree of functional visual impairment, the nature and the degree of secondary handicapping conditions, the nature of the educational setting, and the availability of additional related services. However, although it is the responsibility of the local education agency to assure proper placement of any child who is a resident of that district, it is the responsibility of the coordinator of the statewide program for the visually impaired, i.e., the Director of Educational Services of the Division for the Visually Impaired, to assure 1) that each visually impaired child in the State is identified and 2) that such services as he/she needs to cope with his/her visual impairment are provided.

When another handicapping condition is present, it generally has a more profound effect on educational placement than does visual impairment, thus the Delaware Continuum of Services Model offers a range of alternatives designed to meet the individual needs of all visually impaired children and youth.

A. *Level I—Regular Classroom with Consultant Services*

Visually impaired children with no secondary handicapping conditions, or very mild ones, can be programmed for Level I with itinerant/consultant services from the Division for the Visually Impaired. Such children may be provided with large print books or other curriculum materials and his/her classroom teacher may be given guidance in adapting classroom activities to best meet the child's needs.

B. *Level II—Regular Classroom with Special Education Part-Time Services*

At Level II of the continuum, an itinerant teacher/consultant from the Division for the Visually Impaired provides supportive instruction. Not only are necessary textbooks and special equipment provided, but the teacher/consultant works directly with the child to help him/her to compete on an equal basis in the regular classroom.

C. *Level III—Special Education Classroom with Part-Time Mainstream Experiences* or *Level IV—Full-Time (Full Day) Special Education Classroom*

If a child requires extensive training in adaptive skills such as Braille, orientation/mobility, daily living skills, or needs daily instruction by a specially trained teacher, he/she may be placed in a resource room for the visually impaired administered by a local school district and serving children within a specific region of the State. Generally, such children are in a resource room for part of the day and in the regular classroom for the balance of the day. If a child's educational needs require intensive training for a full day, he/she should be considered to be on Level IV of the Continuum.

D. *Level V—Special School* or *Level VII—Residential Schools and Treatment Centers*

A multihandicapped child placed in a special school, i.e., Level V of the Continuum, or in a residential school or treatment center, i.e., Level VII of the Continuum, he/she may receive itinerant teacher/consultant services from the Division for the Visually Impaired as extensive as the visual impairment requires within the constraints of his/her other handicaps. If it is decided by a state level placement committee that the educational needs of a visually impaired child require placement in a special school for the blind, such a placement could be fully supported by the State.

E. *Level VI – Supportive Instruction at School, Home, or Hospital*

In special homebound cases, i.e., Level VI, the Division for the Visually Impaired may provide parent counseling services and teacher consultation services for the homebound instructor provided by the local school district.

SECTION IV. THE DELIVERY OF SPECIAL EDUCATION AND RELATED SERVICES

A. *Identification and Diagnosis*

The identification of visually impaired children comes about in a variety of ways. A referral usually comes from a parent, school nurse, optometrist or ophthalmologist to the Division for the Visually Impaired. The Division has the ability to pay for an initial eye examination if a current evaluation is not available.

A home visit is made by a Division of the Visually Impaired counselor, and permission is obtained for the itinerant teacher to administer a functional visual evaluation. The Division for the Visually Impaired has the responsibility for notifying the school district special education supervisor of all children in that district who have been referred for services.

B. *The Individualized Education Program (IEP)*

The Individualized Education Plan (IEP), including special education and related services, is the professional responsibility of the specialized interdisciplinary team composed of local school district staff, staff from the Division for the Visually Impaired, and parents. In a more restrictive level, such responsibility is an administrative one, and belongs to the principal through the special education supervisor or coordinator of the special school or facility.

In a less restrictive level, such responsibility is that of the building principal through the special education supervisor in cooperation with the Division for the Visually Impaired. In either situation, immediate coordinative responsibility for the IEP may be delegated to an appropriate staff member.

The IEPs are reviewed annually and new eye examinations and other pertinent evaluations are provided as required.

C. *Program Structure*

1. *Specialized Interdisciplinary Systems—Statewide/Regional Special Schools and Facilities, Intensive Learning Centers, Institutional Settings*

a. *Leadership*

The Division for the Visually Impaired, a comprehensive agency serving the needs of visually impaired persons of all ages, is under the Department of Health and Social Services. However, the Division's Director of Educational Services has program supervisory responsibility for all visually impaired children in the State. The Director of Educational Services is responsible for:

- assuring delivery of educational programming and services to each identified visually impaired child in the State;
- determining the eligibility of a child for programs for the visually impaired in concert with the diagnostic team described in Section IV. B. (Note: For initial referral and placement, it is the joint responsibility of the State coordinator, district of residence, and agency currently providing services to collect the data necessary for IEP meeting deliberations, to ensure appropriate representation at the IEP meetings.);

- assuring that initial placement procedures are conducted properly;
- reviewing all IEPs, with appropriate local district/school and agency personnel participating;
- developing and implementing policies and procedures for the statewide program for the visually impaired;
- maintaining the continuity of the statewide program through active involvement in all aspects of the program with those local school districts, special schools, and State agencies serving visually impaired children;
- facilitating the development and specifics of appropriate administrative compacts with pertinent agencies.

Thus, the Division for the Visually Impaired operates, in effect, as a statewide special school. Two administrative offices shelter the program, one in Wilmington and the other in the Caesar Rodney School District.

b. *Facility Spaces*

It is the responsibility of the local schools wherein the visually impaired child is educated to provide an area for the itinerant teacher/consultant to work with the child. Also essential is a secured area where specialized equipment can be stored.

In some cases, minor adaptations may need to be made within the classroom or school so that the visually impaired child can function to the best of his/her ability. It is the responsibility of the itinerant teacher to act as a consultant and advise the school district staff on how these changes might be made. In most cases, these changes are very minor, involving such things as reduced glare or preferential seating.

The classrooms for the resource rooms are provided by the school districts in which they are administered. Such districts are expected to provide appropriately sized, well-lighted rooms with adequate electrical outlets and secure storage space for specialized equipment. Three such resource rooms are operated in the State as follows: one in New Castle County, administered by the New Castle County School District; one in Kent County, administered by the Caesar Rodney School District, and one in Sussex County, administered by the Milford School District.

c. *Staff Composition*

The director's staff includes itinerant teacher/consultants, child/youth counselors and an instructional materials center director. The resource rooms for the visually impaired, administered by local school districts, are monitored by the Division for the Visually Impaired and by the State Department of Public Instruction and receive supportive consultant services from the Division. Services provided by the administering districts may include speech therapy, testing, homebound instruction, and social services.

d. *Program Components*

The State program can be divided into five basic components:

- The first component encompasses the consultant role that the teachers have in working with child's classroom teachers and staff;
- The second component deals with the actual teaching of the special skills needed by a visually impaired child in order to function effectively;
- The third component involves providing the child with the specialized textbooks, materials, and equipment;
- The fourth component involves the counseling that is provided to both the parents and the child in adapting to the implications of a visual impairment;
- The fifth component involves the instruction of severely impaired students in mobility and orientation skills.

e. *Program Coordination*

Program coordination is a statewide responsibility of the Division for the Visually Impaired, operating in accordance with the *Administrative Manual for Programs for Exceptional Children*. Such coordination shall include program supervision and monitoring in conjunction with the Exceptional Children/Special Programs Division of the Department of Public Instruction. (See also Leadership above.)

f. *Resources*

(1) *Federal*

It shall be the responsibility of the Division for the Visually Impaired working with the State Department of Public Instruction and other State agencies:

- to determine availability of funding and eligibility of the program for those funds:
- to develop proposals as necessary to access such funds;
- to demonstrate that the needs of the participating agencies have been considered in the formulation of project goals and objectives.

(2) *State*

By law, all unit funds generated by visually impaired children are assigned to the placement agency for support of the instructional program. It shall be the responsibility of the statewide coordinator and program staff with other appropriate placement agency personnel to determine program needs as applicable to generated funds.

SECTION V. STAFF PROFESSIONAL GROWTH

Inservice for professional vision staffs can be provided in three ways:

- tuition-free attendance at courses in vision, such as those given by a college or university;
- attendance at special study workshops or institutes sponsored by the Division for the Visually Impaired or other agencies;
- attendance at conferences and seminars in vision and other related areas.

In addition to basic educational experiences, three types of on-going professional development are necessary:

- training in the refinement of teaching skills already attained, such as Braille;
- training in new areas, such as *optacon*, low vision services, and IEP development;
- training in related areas of special education.

One of the most important roles of the itinerant or resource teacher is to provide inservice training for the regular education staff serving a visually impaired child. This may be in the form of a small workshop session, individual consultation, or staff meetings.

In addition, the Division education department runs workshops in subjects related to visual impairment. These workshops include such areas as vision screening, vision stimulation, low vision, and the psychological evaluation of the visually impaired child. Attempts are made to include school district nurses, teachers, and other specialists in these workshops.

SECTION VI. REFERENCES

Ashcroft, S. C., C. Halliday, and N. Barraga. *Study II: Effects of Experimental Teaching on the Visual Behavior of Children Educated as Though They Had No Vision.* Report to U.S. Office of Education, Grant #32-52-0120-1034, Geo. Peabody College for Teachers, Nashville, 1965.

Barraga, Natalie. *Increased Visual Behavior in Low Vision Children.* Research Series No. 13, American Foundation for the Blind, New York, 1964.

____________ ed. *Visual Efficiency Scale.* American Printing House for the Blind, Louisville, 1970.

Fairchild, Thomas and Michael Orlansky, ed. *Mainstreaming the Visually Impaired Child: Blind and Partially Sighted Students in the Regular Classroom.* Learning Concepts, Austin, Texas, 1977.

Faye, Eleanor E. *The Low Vision Patient.* Grune & Stratton, New York, 1970.

Faye, Eleanor E. and Clare M. Hood. *Low Vision: A Symposium Marking the 20th Anniversary of the Lighthouse Low Vision Service.* Thomas, Springfield, 1975.

Hammill, D. D. and J. L. Wiederholt. *Review of the Frostig Visual Perception Test* and the related training program.

Harley, R. K. and J. Spollen. "A Study of the Reliability and Validity of the Visual Efficiency Scale with First Grade Children." *Education of the Visually Handicapped,* 3: p. 88-93, 1974.

Harley, R. K., T. A. Wood, and J. B. Merbler. "Programmed Instruction in the Orientation and Mobility for Multiply Impaired Blind Children." *The New Outlook for the Blind,* 69: p. 418-423, 1975.

Hathaway, W. *Education and Health of the Partially Seeing Child.* 4th ed., Columbia University Press, New York, 1966.

Lowenfeld, Berthold, ed. *The Visually Handicapped Child in School.* John Day, New York, 1973.

Mann, L. and D. A. Sabatino eds. *The First Review of Special Education.* 2 vols., p. 33-48, Grune & Stratton, New York, 1973.

Sheie, H. G. and D. M. Albert. *Adler's Textbook of Ophthalmology.* Saunders Publishers, Philadelphia, 1977.

Sloan, Louise L. *Recommended Aids for the Partially Sighted.* 2nd rev. ed., National Society for the Prevention of Blindness, New York, 1971.

Vaughan, Daniel, T. Ashby, and R. Cook. *General Ophthalmology.* Lange Publishers, Los Altos, California, 1971.

Wolfe, W. G. and J. Harvey. *Comparative Investigation of Methods of Testing Auditory and Visual Acuity of Trainable Mentally Retarded Children.* University of Texas, Austin, 1950.

SECTION VII. GLOSSARY

low vision aids. Any magnifier or device which increases visual functioning.

ophthalmologist. A physician (M.D.) who specializes in diagnosis and treatment of defects and diseases of the eye, performing surgery when necessary or prescribing other types of treatment, including glasses.

optacon. From optical to tactual converter, a machine which allows a blind person to read printed material.

optician. A person who grinds lenses, fits them into frames and adjusts the frames to the wearer.

optometrist. A licensed, nonmedical practitioner who measures refractive errors, i.e., irregularities in the size or shape of the eyeball or surface of the cornea, and eye muscle disturbances. In his treatment the optometrist uses glasses, prisms, and exercises only.

orientation/mobility training. Instruction in the skills and concepts necessary to travel independently (indoors and out).

STATE OF DELAWARE GENERAL GUIDELINES FOR THE DEVELOPMENT OF PROGRAMS OF SPECIAL EDUCATION AND RELATED SERVICES FOR CHILDREN AND YOUTH WITH DEAF-BLIND IMPAIRMENTS

The Delaware Department of Public Instruction

William B. Keene, *State Superintendent*
John J. Ryan, *Acting Deputy State Superintendent*
    Assistant State Superintendent
    Administrative Services Branch
Randall L. Broyles, *Assistant State Superintendent*
    Instructional Services Branch

VII

STATE OF DELAWARE GENERAL GUIDELINES FOR THE DEVELOPMENT OF PROGRAMS OF SPECIAL EDUCATION AND RELATED SERVICES FOR CHILDREN AND YOUTH WITH DEAF-BLIND IMPAIRMENTS

The Delaware Department of Public Instruction

William B. Keene, *State Superintendent*
John J. Ryan, *Acting Deputy State Superintendent*
Assistant State Superintendent
Administrative Services Branch
Randall L. Broyles, *Assistant State Superintendent*
Instructional Services Branch

The State of Delaware is an equal opportunity employer and does not discriminate or deny services on the basis of race, color, national origin, sex, handicap, and/or age.

Guideline Contributors:

Mr. Richard L. Connell, State Supervisor, Exceptional Children Programs, Department of Public Instruction (Guideline Task Force Chairperson)

Mrs. Sheila Gorrafa, State Coordinator, Delaware Statewide Deaf-Blind Program

Mrs. Wanda Hicks, Pre-College Programs, Gallaudet College, Washington, D.C.

Mrs. Susanna Lee, Principal, Margaret S. Sterck School for the Hearing Impaired

Dr. F. Eugene Thomure, Director, Margaret S. Sterck School for the Hearing Impaired

Mrs. Jeanetta Walsh, Educational Diagnostician, Mid-Atlantic North and Caribbean Regional Center for Services to Deaf-Blind Children, New York, Institute for the Blind

DEFINITION:

Deaf-blind means concomitant hearing and visual impairments, the combination of which causes such severe communication and other developmental and educational problems that they cannot be accommodated in special educational programs solely for deaf or blind children, or other handicapping conditions without specialized and unique intervention techniques indigenous to the dual impairments. Additional handicaps of physical, mental, and emotional natures frequently accompany a deaf-blind impairment and require services related to the conditions(s).

(From Section III. G.11 of the Delaware *Administrative Manual for Programs for Exceptional Children*.)

INTRODUCTION

In the identification and description of the deaf-blind population, emphasis must be placed on the multiplicity and uniqueness of the combined handicaps manifested by the majority of deaf-blind children. Unique and complex combinations of exceptionalities impose extraordinary handicapping conditions on the individual child. Such conditions, which either result from or are associated with deaf-blindness, influence and act upon one another, causing serious delays and/or impairments in the deaf-blind child's total development.

The basic system used to identify and classify an individual child requires the use of a model which emphasizes the specific sensory disabilities (deaf-blindness). Such a model establishes the priority handicapping condition(s) for intervention *and* management. It is recognized, however, that the program for each child must respond to the totality of unique physical and developmental needs.

It is imperative that the service delivery system for the deaf-blind emphasizes the multiplicity of the handicapping conditions, the distinctive services needed, the professional staff training required, and the scope of the administrative problem in providing adequate interdisciplinary services in the varied and widely dispersed special schools and agencies.

SECTION I. NATURE OF THE EXCEPTIONALITY

Generalizations may be made regarding the effects of deafness and its implication for educational intervention. Similarly, blindness results in certain predictable problems which educators must address. The two sensory handicaps in combination, however, result in a level of debilitation which far exceeds the mere sum of the effects of each disability, i.e., deafness and blindness.

Additionally, deaf-blindness is often accompanied by other exceptionalities and developmental delays, such as those found with mental retardation, physical impairments, learning disabilities, and language dysfunctions.

Because of the infinite variety and range of variables in the deaf-blind population, identification is an extremely complex and arduous task. For each child the variables which complicate identification and classification will indicate the specific special education and related services that are necessary to intervene effectively and meet the needs of the deaf-blind child. Such interruptions and/or delays in development are affected by the severity, multiplicity, and age of onset of the sensory deprivation. Basically, deaf-blindness occurs in the following ways:

1. An individual may be born deaf-blind. (Many of the rubella syndrome population fall into this category.)
2. An individual may be born deaf and become blind. (Four percent to six percent of the congenitally deaf population have Usher's syndrome.)
3. An individual may be born blind and become deaf.
4. An individual may become deaf-blind. The majority of this group are trauma victims.
5. An individual may function as deaf-blind but display no apparent sensory malfunction during clinical diagnosis.

Accordingly, the intervention process for this complex population requires a comprehensive and dynamic individual case management approach and accountability commitment for each deaf-blind child.

SECTION II. EDUCATIONAL CHALLENGE

The educational implications of deaf-blindness are unique to each child so identified. Thus, the main attempts of each child's program will naturally vary. In some instances, the focus may be cognitively and academically oriented; in other cases, a therapeutic or habilitative model will predominate; and in still other cases, prevocational or vocational training will be the thrust of the program.

Generally, however, the deaf-blind child's total development will necessitate the direct services of a multidisciplinary team. In addition, the deaf-blind child will require, on a continuing basis, other critical special services for evaluative, monitoring, and treatment purposes, e.g., medical, ophthalmological, audiological, dental, and mobility.

Depending on the severity, multiplicity, and age of onset of the deaf-blind child's handicapping conditions, the deaf-blind child may encounter a variety of difficulties or skill impairments within any or all of the following developmental areas:

1. Sensory—impairment of visual and hearing acuity inhibits response to sensory stimuli, their exploration and integration, including an inability to use tactile input.
2. Gross motor—postural and voluntary control, ambulation, orientation and mobility, balance and coordination.
3. Fine motor—hand dexterity and coordination.
4. Cognitive—preoperational, concrete, and formal levels.
5. Communication—receptive, expressive, oral, manual.
6. Self image—concept of own body, laterality, position in space, relationship to people and objects in the environment.
7. Social interaction—with peers, adults.
8. Personal care and independent living skills.

Therefore, the functioning level of the child determines educational programming which aims to develop the ability to pursue self-directed leisure time activities, to interact appropriately with the community, and, ultimately, to use prevocational and vocational skills.

SECTION III. BASES FOR PLACEMENT

With such a complex population requiring such a diverse range of services, no single educational or therapeutic setting can adequately provide for the needs of all deafblind children. Some locations will provide full-time care and services, while others will provide services within the usual school day. Consideration must be given to the availability of appropriate facilities to meet medical needs and may, accordingly, affect educational placement.

Regardless of the actual physical location of the deaf-blind children, their needs necessitate that service be provided through a single, comprehensive statewide program. The options for an appropriate educational environment may be, but shall not be limited to:

1. A self-contained class for the deaf-blind in a(n):
    - institutional setting
    - residential special school
    - special day school
2. A resource room for the deaf-blind in a(n):
    - institutional setting
    - residential special school
    - special day school
3. The services of itinerant teachers of the deaf-blind services in a(n):
    - institutional setting
    - residential special school
    - special day school
    - parent-infant program
    - home

Placement must be flexible within the statewide program and should be changed as the child's progress indicates. Further, placement recommendations must balance all the variables which influence the particular child's learning, with existing program options and the adaptations necessary to accommodate the special needs of that child.

The State Deaf-Blind Program Coordinator directs the child's placement based on the recommendations of the Interdisciplinary Diagnostic Team, insures the provision of full range of services for all deaf-blind children, and assures regular reevaluation of the child.

SECTION IV. THE DELIVERY OF SPECIAL EDUCATION AND RELATED SERVICES

A. *Identification and Diagnosis*

All children being considered or placed in any special education program should be screened by a diagnostic team for the purpose of identifying possible visual and auditory impairments. It has been recognized by authorities within the field that deaf-blindness may result from maldevelopment of the primary peripheral senses, aberrant behaviors or disorders resulting from malfunction of the central nervous system, sensory deprivation, or an inadequate system of sensory integration. Therefore, those persons who should be involved in the initial diagnostic process are:

1. Audiologist and ophthalmologist — to assess the development of the primary peripheral senses.
2. Medical Specialist — to assess the functioning of the central nervous system with relative sensory deficits.
3. Occupational Therapist — to assess intersensory integration.
4. Speech and Language Specialist — to assess receptive and expressive language acquisition.
5. Psychologist and educational diagnostician — to assess specific social, emotional, and educational development.

This diagnostic team is provided by the Statewide Deaf-Blind Program. Eligibility for deaf-blind program services shall be determined by the diagnostic team. However, determination of deaf-blindness should not necessarily be considered a permanent classification. All children diagnosed as deaf-blind should be reevaluated at least every three years or as the child's progress indicates.

B. *Individualized Education Program (IEP)*

After the initial diagnostic evaluation and classification of a child as deaf-blind, provisions are made for the educational programming for the child. The development of the IEP shall be delegated by the State Deaf-Blind Coordinator to an interdisciplinary child study team.

This child study team shall be interagency in nature, being composed of those persons directly involved with the delivery of deaf-blind services in a particular setting, other professionals providing expert advice, and parents or guardians.

The child study team shall function so that the development and implementation of the child's IEP is in accordance with the guidelines set forth under P.L. 94-142 and shall provide for the following:

1. One team member shall be designated by the Statewide Deaf-Blind Coordinator to assume responsibilities for implementation of the child's IEP, including coordination of its development, the identification of priorities, and consultation with team members to identify those responsible for direct and related services.

2. Each team member may make recommendations toward the development of goals to be included in the child's IEP.

3. The team members may or may not be responsible for the direct development or implementation of the child's IEP.

C. *Program Structure*

1. *Leadership*

The Margaret S. Sterck School for the Hearing Impaired serves as the administrative agency for the statewide deaf-blind program. Thus, the Director of the Margaret S. Sterck School for the Hearing Impaired and the State Coordinator of the deaf-blind program are the primary administrators in the statewide deaf-blind program. The State Coordinator, either individually or with the Director, is responsible for:

a. assuring delivery of educational programming and services to each identified deaf-blind child in the state.

b. determining the eligibility of a child for the deaf-blind program in concert with the diagnostic team described in Section IV-A (Identification and Diagnosis). NOTE: For initial referral and placement, it is the joint responsibility of the State Coordinator, district of residence, and agency currently providing services to collect the data necessary for IEP meeting deliberations, to ensure appropriate representation at the IEP meetings.

c. assuring that initial placement procedures are conducted properly.

d. reviewing all IEPs with appropriate local district/school and agency personnel participating.

e. developing and implementing policies and procedures for the statewide deaf-blind program.

f. maintaining the continuity of the statewide program through active involvement in all aspects of the program with those local school districts, special schools, and State agencies serving deaf-blind children.

g. facilitating the development and specifics of administrative compacts with each district.

2. *Facility Spaces*

The State Coordinator for the Deaf-Blind Program will be housed in the Margaret S. Sterck School for the Hearing Impaired.

It is the responsibility of the local school districts wherein the deaf-blind child is educated to provide working areas for the personnel providing direct services to the deaf-blind child.

The State Coordinator and personnel of the participating agencies will cooperatively decide upon and arrange for the equipment, appropriate space, and necessary modifications for the deaf-blind classrooms. Such equipment and changes depend upon the severity and multiplicity of the deaf-blind child's handicapping conditions and might include, but shall not be limited to:

- classroom area access
- audiological amplification equipment
- acoustical treatment of instructional area
- mats, positioning equipment
- adequate electrical service for use of extensive electronic media
- adequate and appropriate lighting

3. *Staff Composition*
Essential to a quality program is the expertise of the staff implementing the instruction prescribed for each individual deaf-blind child. Therefore, provisions for appropriate programming must be met by a staff consisting of:

a. *staff coordinator*—who will coordinate and supervise the delivery of services provided to deaf-blind students.

b. *teachers of the deaf-blind*—who will provide primary direct instruction to deaf-blind students, according to the IEP.

c. *aides*—who will provide instructional assistance and supervision of deaf-blind students, under the direction of the teacher.

d. *related service specialists*—who will provide the appropriate programming in each of their areas of expertise and assist the teacher in maintaining that program in the classroom. This category includes, but is not limited to: occupational therapist, physical therapist, speech therapist, social worker, psychologist, audiologist, ophthalmologist, and/or orientation and mobility specialist.

e. *special education teachers*—who will provide technical assistance to the teachers of deaf-blind students.

f. *other special education and regular teachers*—who will provide instruction for deaf-blind students who are mainstreamed into a special or regular school program.

g. *nursing and supervisory personnel*—who will provide medical and full-time care, particularly in institutional settings.

All services provided through the statewide Deaf-Blind Program will be documented in the IEP through cooperative action of the personnel providing the services in the IEP planning and review meetings.

h. *other administrative personnel*—who will monitor the daily functioning of deaf-blind personnel within their schools, institutions and agencies.

4. *Resources*

a. *Federal*

It shall be the responsibility of the administering agency working with the State Department of Public Instruction and other state agencies:

1) to determine availability of funding and eligibility of the deaf/blind program for those funds

2) to develop proposals as necessary to secure such funds

3) to demonstrate that the needs of the participating agencies have been considered in the formulation of project goals and objectives.

b. *State*

By law, all unit funds generated by deaf-blind children are assigned to the placement agency for support of the instructional program. It shall be the responsibility of the State Coordinator and program staff with other appropriate placement agency personnel to determine program needs as applicable to generated funds.

By law, funds generated for the state coordinator and for related services are assigned to the administering agency.

c. *Local*

The administering agency and the placement agencies shall jointly determine what costs should be borne by the participating agencies and what tuition charges shall be levied against resident districts.

SECTION V. STAFF PROFESSIONAL GROWTH

Combined impairments of vision and hearing necessitate extensive and sophisticated educational and therapeutic intervention. Few deaf-blind children will be able to profit substantially from a program within continuum levels one through three (Delaware *Administrative Manual for Programs for Exceptional Children*—page 20). Highly specialized and individualized programs, facilities, and staffs will continue to be required throughout the school experience for almost all deaf-blind children. Therefore, training opportunities for professional staffs, parents, administrators, and other agency personnel must be characterized by substantive content and focused on topics unique to the needs of such severely handicapped children. All professionals working with deaf/blind children must acquire a full spectrum of special education training. Highly specific topics, case studies, practicum and product workshops are necessary. Specific application of theory to intervention techniques for deaf/blind children is essential. The general guidelines for enhancing the professional growth of the interdisciplinary teams serving the deaf-blind population should provide a systematic framework for the on-going inservice programs essential to consistent quality program development and control on a long-term basis.

1. *General Program Orientations*

   In each facility where deaf-blind students are placed, there should be provisions for on-going interaction between the total staff and deaf-blind personnel so that all personnel become aware of the two (or more) programs and their relationship to each other. Dissemination of current federal, state and local regulations, policies, and priorities pertaining to the deaf-blind should be done periodically.

2. *Specific Program Implementations*

   As a continuous form of inservice training, the staff members will be involved in the review and modification of the instructional and procedural components of the deaf-blind program. Additionally, arrangements will be made for the staff to participate in on-going analysis of the child study team interactions and the effectiveness of the implementation of the IEPs.

3. *Topical Presentations*

   Annual, periodic presentations by interdisciplinary staff members who have participated in recent state and/or national inservice programs are appropriate means of informing all deaf-blind personnel about instructional strategies and advances in technology which can improve the habilitation and/or compensation of the deaf/blind. Particular emphasis should be on the habilitative and compensatory implications of developmental arrest in the areas of sensori-motor development, language acquisition and integration, cognitive development, and the acquisition of basic survival competencies related to personal care and adjustment to different environments.

4. *Model Case Studies*

   As an integral part of statewide inservice programs, periodic visits, at least on an annual basis, by interdisciplinary national specialists in the area of the deaf-blind can expand the expertise of the local interdisciplinary team through collaborative, in-depth study of selected model cases.

5. *Professional Practice*

Ordinarily the type of extended clinical practicum experience afforded by the universities in technical program areas is not appropriate to an inservice program. For the deaf-blind, however, selective annual participation by personnel on a rotating basis can do much to upgrade the quality of the program. Reasonable, limited guarantees of continuation in Delaware by personnel benefiting from such special practica will be expected.

6. *Product Workshops*

From time to time, special inservice institutes may be necessary to develop particular assessment or program materials.

7. *General Topics for Informational Exchange*

Provisions should be made annually for the involvement of parents, medical and health personnel, and community service agencies, and legislators so that their awareness of the deaf-blind program will be strengthened along with their knowledge of the sources and resources models and delivery systems for services which are available for the deaf-blind child.

8. *Workshops*

Provisions should be made annually for professional staff to participate in workshops, symposia, and other meetings concerned with education and medical or related services offered to deaf-blind persons by regional, state, and national agencies.

SECTION VI. REFERENCES

Center and Services for the Deaf-Blind Children, Policies Analysis and Recommendations. Management Analysis Center, Inc., 1225 Connecticut Avenue, N.W. #617, Washington, D.C. 20036, 1973.

Dronek, Margo. *Assessment Tool Comparison.* California State Department of Education, 1977.

English, Jack. "Usher's Syndrome." American Annals of the Deaf: Volume 123, No. 3, May 1978.

Garrett, Jeff. *Teaching Deaf-Blind Children.* A summer workshop for training and instruction of high functioning deaf-blind children; Gallaudet College, Washington, D.C., 1977.

Handbook for Special Education Plan A. Dallas Independent School District, Dallas, Texas, 1976.

Learning Steps: A Handbook for Persons Working with Deaf-Blind Children in Residential Settings. California State Department of Education, 1976.

Proceedings:

The Deaf-Blind Child and the Vocational Rehabilitation Counselor,

The Psychologist, Audiologist and Speech Pathologist and the Deaf-Blind Child,

Basic Assessment and Intervention Techniques for Deaf-Blind and Multihandicapped Children,

Training Occupational, Physical and Recreational Therapists in the Area of Deaf-Blind,

Understanding the Needs of Deaf-Blind Children in Isolated Areas,

Educators of the Deaf, Educators of the Blind, and Educators of the Deaf-Blind,

Workshops for Ophthalmologists, Optometrists, and Educators,

California State Department of Education
Wilson Riles, Superintendent of Public Instruction
Sacramento, 1977.

Policies and Procedure Manual for the Education of Deaf-Blind Children in Louisiana. Louisiana State Department of Education.

Robbins, Nan. "Educational Assessment of Deaf-Blind and Auditorily-Visually Impaired Children." *A Study State of Arts.* September, 1977, Pg. 108-142.

SECTION VII. GLOSSARY

sensory deprivation. Lack of exposure to and/or inability to interact upon sensory stimuli.

perception. Ability of the senses to receive information from sensory stimuli.

sensory awareness. Ability to respond through a single function or process to stimuli imposed upon the senses.

sensory integration. Ability to organize the information transmitted from the stimuli to the senses.

sensori-motor skills. The ability to coordinate two or more functions or processes in such a way that the information from sensory stimuli is interpreted for planning and execution of interaction with the environment.

STATE OF DELAWARE
GENERAL GUIDELINES FOR THE DEVELOPMENT OF PROGRAMS OF SPECIAL EDUCATION AND RELATED SERVICES FOR CHILDREN AND YOUTH WITH SOCIAL/EMOTIONAL MALADJUSTMENTS

The Delaware Department of Public Instruction

William B. Keene, *State Superintendent*
John J. Ryan, *Acting Deputy State Superintendent*
Assistant State Superintendent
Administrative Services Branch
Randall L. Broyles, *Assistant State Superintendent*
Instructional Services Branch

STATE OF DELAWARE
GENERAL GUIDELINES FOR THE DEVELOPMENT OF PROGRAMS OF SPECIAL EDUCATION AND RELATED SERVICES FOR CHILDREN AND YOUTH WITH SOCIAL/EMOTIONAL MALADJUSTMENTS

The Delaware Department of Public Instruction

William B. Keene, *State Superintendent*
John J. Ryan, *Acting Deputy State Superintendent*
Assistant State Superintendent
Administrative Services Branch
Randall L. Broyles, *Assistant State Superintendent*
Instructional Services Branch

The State of Delaware is an equal opportunity employer and does not discriminate or deny services on the basis of race, color, national origin, sex, handicap, and/or age.

Guideline Contributors:

Steven Godowsky, Chairperson, State Supervisor, Exceptional Children Programs, Department of Public Instruction

Rae Burns, Special Education Teacher, New Castle County School District

Richard L. Connell, State Supervisor, Exceptional Children Programs, Department of Public Instruction

Louise Connell-Nichols, Parent/Trainer, New Castle County School District

Linda Foley, Educational Program Specialist, Mid-East Regional Resource Center, George Washington University

Doris LeStourgeon, Director, Pilot School, Inc., Wilmington

Frank Livoy, Special Education Teacher, New Castle County School District

DEFINITION:

Social or Emotional Maladjustment—The child exhibits behavior representative of conflict between self and environment repeatedly and over time to such an extent and duration that it significantly affects the learning process.

a. Acting out behavior, such as unpredicted and unprovoked hitting, aggressive and disruptive behaviors.

b. Withdrawing behavior, such as absence of speech, depression, impulsive and obsessive behaviors.

c. Defensive behaviors, such as compulsive eating, manipulation, or running away from home or school.

d. Disorganized behaviors, such as out-of-touch with reality, self-abusive behavior, lack of self control.

(From Section III. G. 6. of the Delaware *Administrative Manual for Programs for Exceptional Children*.)

SECTION I. NATURE OF THE EXCEPTIONALITY

Social/emotional maladjustment is a dynamic condition which must be viewed from the perspective of the individual's present stage of development, especially its psychosocial aspects, and the characteristic adjustment which he/she makes to prevailing environmental conditions.

In determining the existence of social/emotional maladjustment, behavior must be examined in terms of its appropriateness to the child's developmental stage and the situational stimuli. The key to our understanding of this issue is the concept of appropriateness, which clearly recognizes that behavior acceptable in one situation may be unacceptable in another when the circumstances are significantly altered. There is, however, a lack of concensus among professionals in the field with respect to a commonly adhered to descriptive definition of social/emotional maladjustment.

Fortunately, agreement can be reached when referring to the functional aspects of the problem in terms of specific behaviors and examples.

In this respect, a child is identified as socially/emotionally maladjusted when he/she exhibits one or more of the following characteristics to such an extent and duration that the learning process is significantly affected:

- inability to learn that cannot be explained by intellectual, sensory, neurophysical, or general health factors. (The child exhibits poor or chronic motivation towards school achievement in specific subject areas or exhibits gaps in academic skill attainment);
- inability to build or maintain satisfactory interpersonal relationships with peers and/or teachers. (The child may engage in excessive fighting, is unable to participate in group activities, and shows unwillingness to follow directions);
- inappropriate or immature types of behavior under normal conditions (the child may cry excessively, be confused or unable to cope with group work or sharing materials, or seeks inordinate amounts of teacher attention);
- a pervasive mood of unhappiness or depression (the child may often exhibit dissatisfaction with self, may be withdrawn and need prompting for open communication, may seldom display joy or receive compliments easily);
- a tendency to develop psychosomatic symptoms (the child may complain of frequent headaches or stomachaches, be listless, etc.).

As indicated above, the behavior under investigation must occur with a frequency and intensity that is distinguishable from that of normal age-group peers and does indeed interfere with educational performances.

Furthermore, the behavior should be discernable by more than one staff member interacting with the child, thus reducing the risk of subjective diagnosis. (Bower and Lambert, 1961.)

SECTION II. THE EDUCATIONAL CHALLENGE

The challenge in educating the socially or emotionally maladjusted student is to replace, or modify to an appropriate level, those behaviors that impede learning with those that allow for, or contribute to, learning. By continuous manipulation of such factors as classroom environment, instructional strategies, nature of specific activities (complexity, duration, timing), as well as the consequences of specific behaviors, the special educator attempts to decrease or eliminate the following patterns of behavior:

- short attention span — inability to attend to the point of task completion;
- distractibility — distracted from tasks by ordinary classroom stimuli;
- disorganization — does not seem to know how to plan or complete tasks;
- restlessness or hyperactivity — aimlessly and constantly moves about;
- disruptiveness — unable to conform to classroom rules or routines, annoys or picks on other children, a disturbing catalyst;
- social isolation — stays on periphery of groups, leaves a group while an activity is going on;
- social incompetence — inability to make and maintain friends, or to sustain a relationship;
- avoidance — does not like to come to adults for attention or help, refuses teacher input;
- over dependence — cannot make independent decisions or actions;
- distrustfulness — frequently tests limits and affection of adults and authority figures;
- speech problems — fluency rate, stuttering, and voice levels (loud, soft, reticent);
- unusual language content — creation of nonsense words, excessive profanity;
- extreme aggressive behavior — verbally and physically attacks others, i.e., bullying, taunting, as well as biting, hitting, and kicking;
- poor self-concept — cannot accept compliments easily, does not feel good about self, lacks self-esteem;
- resistance to discipline or direction — disagreeable, hard to manage, not receptive to directions or training;
- compulsive behavior — insists on following inflexible patterns and sequences;
- chronic physical complaints — talks of being sick or hurt, appears tired, lacks physical energy;
- displays of extreme emotion and feelings — exhibits manic behavior;
- excessive fearfulness — demonstrates general anxiety, tenseness, or timidity, exceeding situational stimuli;
- self-destructiveness — does things to hurt self;
- poor reality contact — daydreams excessively, creates fantasy friends and stories to the exclusion of normal involvements;

- manipulativeness — coerces others through inappropriate threats and temper tantrums, and by feigning weaknesses and inadequacies;
- inconsistency in control of bladder and bowel functions;
- habitual attention seeking behaviors — showing off, cannot tolerate delayed gratification, cannot wait for turn, must always be first.

The list of behavioral characteristics described above should be considered as representative of many, but not all, of the types of behaviors which may exhibited by certain socially or emotionally maladjusted children and youth.

SECTION III. BASES FOR PLACEMENT

A. *Specialized Interdisciplinary Systems—Statewide/Regional Special Schools and Facilities, Intensive Learning Centers, Institutional Settings*

Placement in a specialized school or program is essential when the complexity and intensity of the social or emotional maladjustment requires a totally coordinated day-to-day intervention by a specialized interdisciplinary team with the in-depth expertise and specific commitment to the needs of such children and youth.

Special school programs may be operated in a separate school facility or can be housed within the context of a "regular" public school. Educational programming and administrative responsibilities remain distinctly independent in those instances of shared facility space. Opportunities for student integration are available. However, at this level of service, mainstream options are remote and have secondary priority in regard to appropriate instructional opportunities. The needs of students educated through special school programs require additional program structure and staff support beyond that which can be provided within the continuum of special education resource programs in regular public schools.

Supportive Instruction in School, Home, or Hospital Settings

Homebound instruction is a temporary instructional alternative for severely socially or emotionally maladjusted students in transition from one school or program to another. Homebound instructional services are provided by school districts in cooperation with the State Department of Public Instruction and other public agencies.

Residential Schools and/or Treatment Centers

Placement in residential schools or treatment centers is for those severely socially or emotionally maladjusted students who require such extensive program intervention that they must be enrolled in a treatment facility on a twenty-four hour a day basis. Related services and additional supportive personnel for protective care are provided to ensure appropriate educational opportunities.

B. *Mainstream Continuum of Services (With Multidisciplinary Support)—Regular Classes, Resource Rooms, Special Class Settings*

Placement in the mainstream continuum is usually appropriate for the child with mild to moderate social or emotional maladjustment. The intervention components available in such settings involve the "traditional" special education services of academic support, small groups, and interaction. Additional program emphasis includes:

- guidance counseling;
- psychological assessment and counseling;
- special affective education projects and related service options according to student needs.

SECTION IV. THE DELIVERY OF SPECIAL EDUCATION AND RELATED SERVICES

A. *Identification and Diagnosis*

Identification and evaluation procedures for the placement of the socially/emotionally maladjusted individual are the responsibility of the child's local school district, in cooperation with other agencies providing services to the child and his/her family.

The identification of social/emotional maladjustment in children and youth is seriously hampered by the lack of agreement among professionals regarding definitions, assessment, and program philosophy in this area. There is no single model which is universally accepted or ascribed to by the practitioners in the field. When considering identification and assessment of emotional or social disturbances in children, one must be aware of the differences in the models for assessment and the common behavioral characteristics of this population, as well as other students with learning and school related difficulties. In addition, the relationship of the observed behavior, student interactions and relationships, environment, and the developmental context of the child need to be considered in the identification and assessment process and in the ultimate determination of placement of these children and youth.

The behaviors of the child identified as emotionally disturbed overlap considerably with the behaviors exhibited by children with other exceptionalities. The behavior exhibited by emotionally or socially maladjusted children is often only distinguishable from that of "typical" children by its frequency, duration, intensity, and degree of appropriateness. The latter dimension of the relatively consistent appropriateness of behavior in the various contexts of an individual's life is probably the most significant indicator of his/her overall adjustment or maladjustment.

The purpose of assessment is twofold: identification, to determine that the condition does exist; and programming, to develop instructional strategies and intervention techniques that are designed to alleviate or treat the student's present deficiences. A single test or instrument rarely provides sufficient data to accomplish both. Data must be collected from a variety of sources such as, but not limited to, those listed below:

- education evaluation;
- psychological and/or psychiatric reports;
- behavioral rating and/or adaptive behavior scales;
- medical reports, (especially when drug therapy is part of an intervention program);
- social/developmental histories;
- parent interviews and home visits;
- observation.

Identification procedures for the emotionally handicapped student in the public schools remain an area of significant professional disagreement. According to Hobbs, the present state of the art for effectively identifying students with emotional difficulties has progressed little since 1975.

It is, therefore, imperative for educators to be aware of the existing models for assessment used in the identification of the emotionally handicapped. Those models include the: Biophysical, Behavioral, Psychodynamic, Sociological, and Ecological. From the Biophysical standpoint, emotional disturbance is conceptualized as a disease or pathology within an individual resulting from a biological anomaly alone or precipitated by environmental conditions. The Behavioral model primarily concerns itself with present exhibited behavior identified as needing change. The Psychodynamic views disturbance as a failure of the child to deal successfully with internal and external conflict, whereas the Sociological model emphasizes society's role in "creating" deviance and the Ecological recognizes conflict within the child, but places its emphasis on the interface between the child and his/her environment. Each model prescribes specific measures to be built into the assessment process. Although the models are based on divergent assumptions and philosophies, each can contribute to the development of a successful program of educational and developmental intervention for the social/emotional child.

The critical issue in the relevance of the models is the nature and context of the problem(s) to be resolved.

It is equally important that professionals involved do not make assumptions, apply statistics, or interpret data using the theories exclusively from one model, but incorporate the derived data from a variety of measures in order to appropriately assess behavior for identification and programming purposes.

The introduction of the multidisciplinary or interdisciplinary team approach, which may employ the services of psychologists, counselors, educational diagnosticians, reading specialists, occupational therapists, and other support staff, not only facilitates collection and summarization of data, but serves to insure the comprehensive understanding of the child's cognitive and affective learning needs as well as the home and school environment. A comprehensive analysis of the child's class situation, peer interactions, and home environment, as well as individual psychological and medical evaluations, is essential to ensure the most effective recognition, understanding, and treatment of these students.

B. *Placement Responsibilty*

Child study teams or IEP (Individualized Education Program) planning committees, comprised of members from the student's school of attendance, are responsible for making placement decisions as well as determining a student's eligibility for special education and related services.

Operationally, these teams function similarly with respect to the socially or emotionally maladjusted population as they do for children with other handicapping conditions. A multidisciplinary or interdisciplinary approach utilizing the services of psychologists, psychiatrists, counselors, educational diagnosticians, reading specialists, occupational therapists, and other support staff is utilized. This ensures that sufficient datum from a variety of pertinent sources is gathered and that an understanding of the child's affective, cognitive, and psychomotor needs are considered in the development of a suitable intervention strategy. Personal awareness, sensitivity, and caution will be required by professionals who serve on committees addressing the placement of special need students so that children who may be exhibiting behavior in reaction to their present negative physical and/or psychological climate are not indiscriminately labeled as socially or emotionally maladjusted. As previously mentioned, information about the child's class situation, peer interactions, and home environment plays an integral role in the assessment process as does information produced from psychological and medical evaluations.

Data generated from initial screening, referral, and assessment processes, together with input from other relevant sources, must be adequate to:

- determine the relative contribution(s) of environmental conditions and/or inter-personal dynamics to the present deviant behavior;
- delineate the specific educational needs of students so that they can be served through an appropriate program and/or individualized intervention strategy.

Upon the collection of sufficient data and its interpretation, the committee conducts a meeting. At this meeting the child's individualized education program (IEP) is developed and a final determination of placement is made. On-going evaluation is conducted to ensure the appropriateness of the placement and program. When necessary, modifications and changes may be made in the IEP.

The participants at the IEP meeting must include those individuals as prescribed for under the authority of PL 94-142 and the rules and regulations from Delaware's *Administrative Manual for Programs for Exceptional Children*.

C. *Individualized Education Program (IEP)*

The delivery of any service to the socially or emotionally maladjusted student should follow a properly prescribed and developed IEP. That plan is a detailed description of the total service and instruction program prescribed for the individual student. Such a plan should encompass all special education and related services determined as essential to fulfill the specific intervention goals and objectives developed by the IEP team. The development of such an IEP must precede any decision as to the individual student's most appropriate placement.

The IEP is the result of collaboration among several members of the district or school Identification, Placement, Review, and Dismissal (IPRD) Committee, parents, and, when appropriate, the student. The IEP must be reviewed at least on an annual basis. Its development, coordination, and implementation is normally the responsibility of the local school district. In those cases where the student is placed in alternative, regional, or private school programs, the responsibility for the continued development of the IEP and delivery of services resides with the receiving school program, but must include a representative of the sending school district and the child's parents for all major changes in program placement and for the annual IEP review. These are minimal requirements in accordance with PL 94-142 and Delaware's *Administrative Manual for Programs for Exceptional Children*.

D. *Staff Composition*

The educational background of staff providing services for SEM students should include special education training and a broad range of knowledge and expertise in instructional techniques, counseling, and behavior management. Due to the complexity of problems exhibited by these children, the classroom teacher will often require interdisciplinary team cooperation and support to develop and implement an appropriate IEP.

Interdisciplinary team cooperation also serves to foster and maintain behavioral adjustment in the emotional, social, and learning areas. Coordination of related services and support personnel is an integral component of successful programming of SEM students. Contingent upon the scope and intensity of the program, the staff and support personnel to implement special education programs for SEM students should include appropriate provision for the following types of services:

- principal and/or administrator of exceptional children programs—responsible for overall supervision and coordination of the program;
- special education teachers certified in the areas of social or emotional maladjustment;
- psychologist and/or psychiatrist;
- school social worker/home/school coordinator;
- guidance counselor;
- school nurse;
- physical education and/or adaptive physical education teachers;
- prevocational and/or vocational education teachers;
- speech and language therapist;
- reading specialist;
- behavior manager/crisis intervention specialist;
- parent trainer/counselor;
- work adjustment specialist;
- human relations specialist;
- art, music, and recreational therapists.

E. *Program Components*

The primary responsiblity for educating the socially or emotionally maladjusted rests with the local school district. Placement decisions and educational services to be provided will be determined by the committee developing the IEP prior to any student's inclusion in a special education program.

A full continuum of educational services, ranging from regular class participation to 24-hour residential school programming, should be available to SEM students according to their individual needs, as stated in the IEP. All such programs must function to maintain children in the least restrictive setting. As the child's needs change, viable program alternatives in the Delaware Service Continuum must respond to those changes.

In the more restrictive service levels of the Delaware Continuum, a total management approach utilizing program and inter-district/agency staff is essential to provide full educational opportunities specifically designed for these exceptional children. School programs should draw from the resources of mental health clinics of the Division of Mental Health, Department of Health and Social Services, and other mental health service providers.

For very seriously disturbed youngsters, who demonstrate the need for residential or regional programs, the responsibility for placement and educational intervention becomes a shared relationship involving interagency coordination between the sending and the receiving schools and/or agencies and the parents.

Success in programming for social/emotional maladjustments in students can best be achieved with full parent involvement and commitment. To insure such involvement and commitment, programs serving the SEM student should:

- establish and maintain open, on-going, consistent communication between home and school;
- train and counsel parents in specific instructional and behavior management techniques.

Open communication between home and school serves not only to reinforce program goals, but to inform both parties of pertinent changes in the student's progress and development. To achieve this end, consistent communication between the home and school is encouraged. Parents or teachers should be notified of events which could alter the child's mood or behavior. Such communication may also serve as a source of reinforcement to parents and students. The degree of parental involvement and training will depend on the complexity and severity of the child's social or emotional handicap. Home-school intervention strategies should be designed by school professionals with the cooperation and assistance of parents and guardians. It is suggested that programs for the seriously socially/emotionally maladjusted include a comprehensive parent-training model which encourages open communication between home and school and a shared commitment and responsibility for the student's education.

The unique characteristics and needs of this student population demand that the environments utilized and created for program implementation provide an appropriate space and atmosphere conducive to learning and adjustment. Each school or facility serving the SEM children and youth should include the following areas or provide access to them:

- instructional center/classroom;
- health center;
- physical education area;
- media center;
- lavatory facilities;
- lunchroom facilities;
- prevocational/vocational training center;
- home living center.

Additionally, in each of these areas the characteristics of safety, flexibility, practicability, optimal distraction-free arrangements, and age appropriateness must be considered and incorporated into the program and facility design.

Facility space and equipment serving the more seriously socially or emotionally disturbed may also include:

- time-out areas;
- music, recreation, and art therapy centers;
- demonstration classrooms/observation rooms, equipped with video and audio monitoring systems and one-way windows;
- areas for individualized instruction to minimize distractions, e.g., people, noise, etc.

SECTION V. STAFF PROFESSIONAL GROWTH

A staff development program for persons serving children identified as socially/emotionally maladjusted can only be considered appropriate and constructive when such children are viewed within the contextual framework of personal development and present environment. It is critical to remember that special education is a process for any handicapped child, regardless of the length of time such a process may continue. However, for children identified as socially or emotionally maladjusted, failure to remember such a fact automatically limits the context within a specific time period and seriously affects the instructional and corrective strategies and techniques suggested to meet the needs of such children.

Equally important to remember in a staff development program is the lack of concensus among professionals as to the correct approach to the needs of SEM children. Emphasis on one model to the exclusion of others, e.g., the psycho-educational model, the ecological model, etc., may well deprive staff persons of an understanding of a variety of important and effective methods for dealing with the needs of such children. Further, children moving from one agency to another may move across philosophical boundaries. Accordingly, data are often viewed differently and may suggest different, or even conflicting, viewpoints. Confronted with professionals who are either unaware of, or who refuse to acknowledge the value of, different theoretical approaches, parents may become confused and discouraged. The child may be negatively affected. The more transient nature of social or emotional maladjustment as opposed to the more guarded and frequently irreversible handicaps, such as sensory or physical impairments, suggests the need for flexible teaching styles which can embrace different theoretical alternatives when circumstances suggest a different approach.

Suggested training packages include:

at the local level—

- case history and classroom consultation by specialists in behavioral, social, and developmental psychology concerning such topics as behavioral strategies, language therapy, life space interviews, etc.;
- intradistrict communication on policies, procedures, problems, concerns;
- planned attendance at national and regional meetings with structured opportunities for sharing;

at the statewide or regional level—

- Federal and State laws, rules, and regulations;
- interpretation of test data;
- curriculum design;
- behavior management techniques;
- update on theory, research, and development in the field;
- planned reporting and sharing on national and regional meetings, exemplary and quality programs;
- provision of consultants and resource persons in special areas, such as art, music, and recreation therapy;
- prevocational and vocational training;

at the interagency level—

- coordination and cooperation with institutions of higher learning
  - —to maximize credit earnings for workshop participants,
  - —to improve the relationship between pre-service training and classroom realities,
  - —to increase the use of practicum opportunities,
  - —to provide for sharing between agencies on needs, strategies, problems, and concerns,
  - —to improve the information process of the school and community so that children and parents are not confused or frustrated in moving from one agency to another for services.

SECTION VI. REFERENCES

Bower, E. and N. Lambert. *In-School Screening of Children With Emotional Handicaps.* Educational Testing Service, Princeton, N.J., 1961.

Coulter, Alan W. and Henry W. Morrow. *The Concepts of Emotional Disturbance Within Special Education.* Ch. 1, Draft, Learning Resource Center, Austin, Texas, 1978.

Emotionally Handicapped Pupils: Developing Appropriate Educational Programs. Division for Exceptional Children, Department of Public Instruction, Raleigh, N.C., 1977.

Foley, Linda S., ed. *Programming for the Emotionally Handicapped: Administrative Considerations.* Proceedings from a conference sponsored by the Media and Regional Resource Center and Coordinating Office for Regional Resource Centers, Washington, D.C., 1977.

Hewett, F. *The Emotionally Disturbed Child in the Classroom.* Allyn & Bacon, Boston, 1968.

Hewett, Frank M. and Steven Forness. *Education of Exceptional Learners.* Allyn and Bacon, Boston, 1974.

Hobbs, N. "Helping Disturbed Children: Psychological and Ecological Strategies." *American Psychologist,* 1966, *21* (12) 1105-1115.

Long, Nicholas J., William C. Morse, and Ruth G. Newman. *Conflict in the Classroom.* 2nd ed., Wadsworth Publishing Co., Inc., Belmont, California, 1971.

Morse, W. C. and V. Dyer. "The Emotionally and Socially Handicapped." *Review of Educational Research,* 1963, *33* 109-125.

Provision of Full Services to Emotionally Handicapped Children. Division for Exceptional Children, Department of Public Instruction, Raleigh, N.C., 1977.

Redl, F. and W. W. Wattenberg. *Mental Hygiene in Teaching.* 2nd ed., Harcourt Brace, New York, 1959.

Rhodes, W. and M. Tracy. "A Study of Child Variance." Vol. I, *Conceptual Models.* The University of Michigan Press, Ann Arbor, Michigan, 1974.

SECTION VII. GLOSSARY

adaptive behavior. Child's ability to perform the social roles appropriate for persons of his/her age and sex in a manner which meets the expectations of the social system in which he/she participates.

affective learning. Refers to those influences on the emotional aspect of education and/or ideas of students.

appropriate education. Means sound, special education including classroom instruction, physical education, home instruction, and related services as required. Refer to the Delaware *Administrative Manual for Programs for Exceptional Children* for complete definition.

behavior modification. Refers to procedures and techniques designed to influence behavior change.

cognitive. Refers to the psychological processes involved in the formation and utilization of symbols and concepts during thinking, reasoning, and problem solving.

continuum of services model. Administrative alternatives from the least restrictive to most restrictive program placement according to each exceptional child's needs.

developmental stage. Refers to a child's maturational level as compared to age level expected behaviors.

distractibility. Inability to attend only to pertinent stimuli. Easily diverted by environmental stimuli.

duration. Refers to the amount of time a given behavior is observed.

dynamic condition. Environmental situations which result in changing behaviors and attitudes.

frequency. Refers to behavior occurring significantly more or less often also known as excesses and deficits.

homebound instruction. Refers to supportive instruction provided to an individual in the home, hospital, or school.

intensity. Refers to the level of behavior exhibited or observed.

interdisciplinary team. Refers to the coordinated delivery of special education and related services by teachers and specialists working together as a team in the development and implementation of the Individualized Education Program (IEP) Plan.

IPRD Committee. Refers to the Identification, Placement, Review, and Dismissal Committees in each school district.

least restrictive environment. An educational placement made as close to the regular class setting as is appropriate to individual student needs.

measures (educational test, etc.). Refers to the tests, observations, and other informal procedures which result in the identification of behaviors that determine a handicapping condition.

milieu. Refers to the setting or environment of the school and program.

models of emotional disturbance/social maladjustment.

biophysical—Refers to emotional disturbance in psychiatric terms and conceptualizes E.D. as a disease or pathology within the individual, resulting from a biological anomaly acting alone or precipitated by environmental conditions.

behavioral—Considers the specific behaviors identified as needing change. Incorporates task analysis, token reinforcement, and contingency management with regard to treatment/education approaches.

psychodynamic—Views disturbance as a failure of the child to deal successfully with a variety of internal and external conflicts. Incorporates the teaching of Freud in its conceptual model.

sociological—Emphasizes society's role in "creating" deviance when rules within the community do not meet the individual's psychological needs.

ecological—Recognizes conflicts within the child, but emphasis is placed on the interface between the child and the environment. Model deals with all aspects of the disturbance.

psycho-motor. Pertains to the motor effect of psychological processes.

resource room. A classroom facility that provides special education for students during specific periods of a school day.

self-contained special education class. Refers to those special education classrooms in which exceptional children spend all or most of the instructional day.

time out. The removal of a student from a situation of the people for reinforcement. Time out is presented contingently upon some response of the pupil and is considered a form of behavior modification.

timing. Refers to behavior occurring at various (inappropriate) times, (often known as private versus public behavior).

STATE OF DELAWARE GENERAL GUIDELINES FOR THE DEVELOPMENT OF PROGRAMS OF SPECIAL EDUCATION AND RELATED SERVICES FOR CHILDREN AND YOUTH WITH AUTISM

The Delaware Department of Public Instruction

William B. Keene, *State Superintendent*
John J. Ryan, *Acting Deputy State Superintendent*
Assistant State Superintendent
Administrative Services Branch
Randall L. Broyles, *Assistant State Superintendent*
Instructional Services Branch

STATE OF DELAWARE
GENERAL GUIDELINES FOR THE DEVELOPMENT OF PROGRAMS OF SPECIAL EDUCATION AND RELATED SERVICES FOR CHILDREN AND YOUTH WITH AUTISM

The Delaware Department of Public Instruction

William B. Keene, *State Superintendent*
John J. Ryan, *Acting Deputy State Superintendent*
Assistant State Superintendent
Administrative Services Branch
Randall L. Broyles, *Assistant State Superintendent*
Instructional Services Branch

The State of Delaware is an equal opportunity employer and does not discriminate or deny services on the basis of race, color, national origin, sex, handicap, and/or age.

Guideline Contributors:

* Steve Godowsky, State Supervisor, Exceptional Children Programs, Department of Public Instruction (Guideline Task Force Chairperson)

* Gail Boyle, Teacher of Exceptional Children, New Castle County School District

* David Bradley, Teacher of Autistic School Programs, New Castle County School District

Gerri Brown, Program Coordinator, Gateway Program, Orlando, Florida

* Janine Carello, Psychologist, New Castle County School District

* Louise Connell-Nichols, Parent-Trainer Autistic Program, New Castle County School District

William Conrad, Principal, John S. Charlton Special School, Caesar Rodney School District

* Mary V. Lauderbaugh, State Supervisor, Direction Service Center, Department of Public Instruction

Lee Marcus, Clinical Director, Piedmont Center, TEACCH Program, University of North Carolina

* Maggie Thomas, Teacher of Autistic Children, Private Residential School

Karen Uncapher, formerly Principal, Charles Bush School; presently Supervisor of Special Education, New Castle County Vocational-Technical School District

*Core Draft Team

DEFINITION:

Autism — Refers to children who have been determined by individual psychological or psychiatric examination to have the specific disability of autism. The behavior manifestations of autism include some combination of the following: Inability to use language for appropriate communication, a history of inability to relate appropriately to other individuals and continued impairment in social interaction from infancy or early childhood, an obsession to maintain sameness, a preoccupation with objects and/or inappropriate use of objects, extreme resistance to controls, and/or exhibition of peculiar motoric mannerisms and motility patterns.

(From Section III. G. 8. of the Delaware *Administrative Manual for Programs for Exceptional Children.)*

SECTION I. NATURE OF THE EXCEPTIONALITY

Autistic children are typically multihandicapped in their abilities to receive and communicate information through one or more of the sensory modalities, resulting in behavior inappropriate to the physical and social demands of their environment. The dominant communication disorder or learning disability appears to result from the inability to use and to understand language appropriately. The difficulty is often accompanied by impairment in sensory-motor, visual, and auditory perception. The behavior of an autistic child is typically improved by the application of appropriate educational procedures. A combination of some or all of the following behaviors characterizes the autistic child. These behaviors vary from child to child and time to time in severity and scope.:

- severe impairment of speech or lack of speech—
  - —echolalia, jargon, and word order confusion,
  - —poor volume control and inappropriate inflection,
  - —inability to understand and/or process verbal or nonverbal communication,
  - —autism,
  - —pronomial reversals,
  - —rote-like, memorized phrases and expressions;
- impairment or complete lack of appropriate relatedness or interaction with children, parents, adults, and objects—
  - —avoidance of eye contact,
  - —abnormal degree of detachment or nonaffection,
  - —abnormal degree of attachment to objects,
  - —grossly inappropriate behavior reactions (e.g., tantrums, inappropriate laughter);
- extreme distress due to minor non-discernible changes in the environment (structure or time);
- lack of intellectual development or retardation in language and cognition, although sometimes accompanied by normal or superior abilities in other areas;
- repetitive, peculiar, and inappropriate use of toys and objects—
  - —bizarre mannerisms,
  - —self-stimulation (e.g., hand flicking, humming),
  - —repetitive body motions (e.g., rocking, spinning),
  - —ritualisms and/or repetitive behavior;
- unusual reaction to perceptual stimuli, such as seeming not to hear certain sounds and over-reacting to others, holding hands over ears, "looking through" objects, and poor eye contact;
- inability to perform certain gross and/or fine motor activities (e.g., walking

with a peculiar gait, limpness in fingers, inability to hold a pencil appropriately);

- onset of disorders at birth or apparent normal early development followed by failure to maintain normal functioning, especially in critical cognitive and communicative areas;
- tendency to fixate on the extreme polarities of behavior—
  - —hyperactivity or passivity,
  - —apparent insensitivity to pain or hypersensitivity to tactile stimulation;
- self-injurious and aggressive behavior.

Autism is usually identifiable before 36 months of age. The rate of incidence is approximately four or five per 10,000 births and is found four to five times more commonly in males. Current research estimates 60% of the autistic children have measured IQs below 50; 20% measure between 50-70 and 20% measure at 70 or above.

SECTION II. THE EDUCATIONAL CHALLENGE

Due to the severity and complexity of the autistic syndromes, most autistic children will usually require in some degree a protective, sheltered environment for the rest of their lives. For this profoundly disabled population the full integration of services is an ultimate goal. In order to achieve this goal, there is the need for comprehensive programming with appropriate instructional and related services in an environment where the student will have the opportunity to identify with appropriate role models, so that normal behavior can more readily become a part of the child's behavioral repertoire. Experience has shown that the achievement of this goal is an extraordinary challenge of long duration.

Because of the learning deficits, developmental delays, and peculiar behavioral characteristics of the autistic child, difficulties in the educational process may be encountered in many areas. The extent and nature of these difficulties vary from child to child. For this reason, the program structure for the autistic must be carefully detailed. Major aspects of the program include:

- behavior management to develop the abilities—
    - —to relate or interact appropriately to children, parents, adults, and objects,
    - —to behave appropriately in social context,
    - —to control inappropriate, peculiar, repetitive mannerisms and self-stimulative behavior,
    - —to comprehend cause and effect relationships;
- self-help and independent living skills to develop the abilities—
    - —to care for one's basic needs, including toileting, dressing, and personal hygiene,
    - —to perceive and react appropriately to dangers and/or normal emergencies;
- learning academic and communication skills to develop the abilities—
    - —to imitate and maintain eye contact,
    - —to imitate and/or respond to a model,
    - —to follow verbal and/or nonverbal directions,
    - —to communicate basic needs,
    - —to initiate and maintain appropriate and meaningful verbal and/or nonverbal communications,
    - —to communicate desires and/or thoughts, allowing for optional participation in academic and social activities,
    - —to sustain attention to tasks;
- motor and sensory-motor development to develop the abilities—
    - —to use and integrate the sensory modalities,

  - to use fine motor control (e.g., holding pencil, tying, and buttoning),
  - to use gross motor control;
- transportation skills —
  - to board and ride a bus in an appropriate fashion.

Although integration into mainstreamed classrooms may occasion specific learning and behavior problems due, in part, to the difference or change of structure in the regular classroom, the efficient integration of the autistic child into the daily operation of a regular school environment is an eventual program goal.

SECTION III. BASES FOR PLACEMENT

It is the responsibility of the evaluation team to gather available data through the referral, screening, and identification process, as well as any additional relevant information sources which will assist in reaching appropriate placement decisions. The IEP planning committees reviewing the eligibility for placement of autistic children into public and/or private school programs should also seek to determine and recommend additional supportive services and personnel, whenever appropriate, in order to meet the needs of these exceptional children.

The syndrome of autism is considered to be one of the most difficult and complicated developmental disabilities to understand and to treat. Wide differences in the severity of the syndrome, lack of specific identifiable physical features, and the conflict existing among professionals concerning etiology, diagnosis, and treatment are but a few of the major issues which have resulted in the nationwide dilemma impeding consistent placement and programming. It is also important to realize that the autistic syndrome is a lifelong disability due to its fundamental biological or organic nature and will require a continuity of programming across time.

Program placement decisions made for autistic children have tremendous impact on the lives of both the child to be placed and his/her parents. It is, therefore, imperative that all placement decisions be comprehensively based on the individual needs of each student's learning characteristics and corresponding needs as reflected in the IEP.

A. *Specialized Interdisciplinary Systems—Statewide/Regional Special Schools and Facilities, Intensive Learning Centers, Institutional Settings*

A major goal for all placement is progression from a more restrictive to a less restrictive environment according to the nature and needs of the individual child. *However, autism is a very severe disorder. It would be unrealistic to believe that all autistic children could be integrated into a less restrictive environment with "normal" children in a self-contained classroom or a resource room.* In any event, the following continuum of services does provide a broad framework of placement options for this population.

Special School

Special schools should provide a full-day structured program which includes educational and behavioral intervention, recreational therapy, parent training, and related services in a 10 to 12 month day-school setting. In public schools the age placement is from 4-21 years, consistent with the rules and regulations for exceptional children programs. At the present time, additional support services for the 0-4 population is available statewide through a Developmental Disabilities Council grant providing training within the home environment for identified autistic children and their parents.

Residential Placement

In this 24-hour supervised program, a format of consistent educational and behavioral intervention, parent training, and related services is provided. A year-round placement may be necessary for programming, depending on the nature and severity of the individual's disability. It must be recognized that effective reintegration of the child into the home is quite difficult and requires a major commitment on the part of all staff and parents.

B. *Mainstream Continuum of Services (With Multidisciplinary Support) — Regular Classes, Resource Rooms, Special Class Settings*

Regular public school programs include a continuum of services from self-contained special school placement to integration into the regular classroom.

Full-time Special Education Program

Public school programs following the Delaware continuum of service model offer programming from full-time, self-contained special education situations to less restrictive placement in regular education classrooms. All support programs at this level function with interdisciplinary teams which may consist of special and regular education teachers, parent trainers, reading specialists, educational diagnosticians, psychologists, speech pathologists, physical therapists, occupational therapists, and other professionals. The primary responsibility for the delivery of direct educational services to the child centers on the program teacher.

Mainstream Concept

Resource rooms which are staffed by special education teachers offer support to students and staff within the regular classroom environment. Special class placement also provides mainstreaming for selected activities and subjects within the regular class or with specialists in areas such as art, music, physical education, or other school programs. A third level of services is the resource center which provides diagnostic/prescriptive intervention and observation, and consultative services to teachers of students referred to the child study team. This service includes counseling with students and parents, and the coordination of services between related agencies dealing directly with the family.

SECTION IV. THE DELIVERY OF SPECIAL EDUCATION AND RELATED SERVICES

A. *Identification and Diagnosis*

1. *Identification*

Initial identification of an autistic child may be made by a parent, physician, teacher, psychologist, or any other agency or person in contact with the child.

An autistic-like behavior is recognizable at an early age (prior to 36 months), therefore, the autistic child should be diagnosed as soon as possible by a variety of professionals dealing with the child. Children exhibiting autistic characteristics should be referred to one of the programs for the autistic to further substantiate the diagnosis and to plan for educational intervention.

2. *Referral*

Most referrals of autistic children originate from educational institutions, social service agencies, or physicians. A staff member from the autistic program, in cooperation with the referring agencies, will investigate these referrals by establishing a developmental, psychological, and medical history and by evaluating the child with a behavioral checklist.

3. *Evaluation*

Responsibility for identification rests with the staff members from the autistic program or with agencies providing diagnostic services, in conjunction with psychological or supportive service providers in the referring district. These staff members should obtain medical records and perform the necessary evaluation for diagnostic and prescriptive purposes. Comprehensive evaluation should include, but is not limited to, the following areas:

- Parent interview/developmental history;
- Behavioral observations (home, classroom, etc.);
- Comprehensive physical examination—
  - —vision/hearing tests,
  - —neurological examination, if necessary;
- Behavioral assessment—
  - —Rimland's Diagnostic Checklist for Behavior Disturbed Children (Rimland Scale of Autistic Behavior),
  - —TARC—Assessment Inventory for Severely Handicapped,
  - —AAMD—Adaptive Behavior Scale,
  - —Psychosis Rating Scale (Schopler, Reichler),
  - —Checklist of Autistic Behaviors (Gateway),
  - —Autistic Behavior Checklist,
  - —Vineland Social Maturity Scale,

- Psycho-educational Profile (PEP);

- Intellectual assessment—
  - Leiter International Performance Scale,
  - Bayley Scales of Infant Development, if applicable,
  - Merill-Palmer Scale of Mental Tests,
  - Portions of the WISC-R, Binet, or McCarthey, if applicable;
- Language assessment—
  - REEL—Bzock—League Receptive—Expressive Emergent Language Scale,
  - Peabody Picture Vocabulary Test,
  - Carrow Test of Auditory Comprehension of Language;
- Developmental assessment—
  - Denver Developmental Screening Test;
- Achievement assessment, if applicable—
  - Criterion Test of Basic Skills,
  - Peabody Individual Achievement Test,
  - Key Math,
  - Woodcock Tests of Reading Skills;
- Informal Test of Auditory/Visual Perception and Motor Development.

In order to achieve the appropriate measurement and assessment of autistic children, an evaluator should have the cooperation of the child. Therefore, testing techniques must be those which use a child's play or typical behavior activities as a starting point.

B. *Individualized Education Program (IEP)*

The development and implementation of the IEP, including special education goals and related services, is the shared responsibility of the sending school district, involved public and/or private agencies, parents, and the regional autistic program. In the more restrictive environments, in order to determine and define the responsibilities of those agencies delivering services, the coordination and provision of service from more than one agency should be reflected in the IEP.

In order to provide educational intervention through the IEP in public school settings, autistic children will require intensive special education and supportive services because of the severe nature of their impairment. These services will include a highly structured task-oriented program of developmental activities based on the individual child's nature and needs. Principals of behavior modification are applied systematically to intensify the learning process. Goals of the IEP should also include positive changes in adaptive and social behavior to allow the individual to move toward a more academically or vocationally oriented program in a less restrictive environment. The ultimate goal of the IEP is to foster the development of each child in his/her effort to become maximally independent within the range of his/her abilities. The objective criteria and evaluation procedures for determining the positive impact of the IEP will require continual monitoring in addition to the annual review defined in State and Federal law. In this respect, the evaluation of student progress is a daily, on-going process of the instructional program.

C. *Program Structure*

1. *Specialized Interdisciplinary Systems—Statewide/Regional Special Schools and Facilities, Intensive Learning Centers, Institutional Settings*

a. *Leadership*

In order to provide appropriate educational programs for autistic children and youth in the more restrictive levels of the Delaware Continuum of Services Model, a total management approach involving staff, administration, resource specialists, and parents is essential to meet the complicated and diverse needs of these exceptional children. To this end, public and private school programs offering educational services specifically designed for the autistic child should be coordinated and supervised by a qualified administrator.

Program placement at the more restrictive levels, i.e., institutional, private residential, and special school settings, entails both administrative and staff responsibilities for ensuring continual monitoring and evaluation in all aspects of social, emotional, and academic development, so that, when appropriate, a student can successfully be integrated into a less restrictive environment.

b. *Facility Spaces and Equipment*

Each special school or facility for the autistic child should include or have access to:

- instructional areas (location in a low-noise, minimal distraction area) ;
- physical education areas (including adaptive physical education area and outside enclosed playground) ;
- prevocational training areas (e.g., industrial education, home arts facilities, etc.) ;
- health center;
- comprehensive media center (library, curriculum A-V components, etc.) ;
- administrative area.

Each instructional area within a special school or facility should include or have access to:

168

- areas for group instruction;
- areas for individual instruction, with provisions made to minimize auditory and visual distractions;
- time-out area;
- bathroom;
- sink and running water;
- out-of-reach or locking storage space;
- observation window (plexiglass);
- carpeting on all or part of the floor;
- nonbreakable windows.

c. *Staff Composition*

All personnel engaged in direct services with the autistic child should have training and experience in basic behavior management and instructional techniques. Special provision must be made for an adequate level of services in each of the following areas:

- special education;
- speech and language therapy;
- parent training;
- occupational therapy and/or adaptive physical education;
- recreational therapy;
- transportation (driver and aide(s)).

Additional consultation through discretionary provisions for social workers, guidance counselors, librarians, art and music instructors, and physical education instructors will be determined and recommended by the supervising administrator, based on his/her analysis of the actual needs of the assigned pupil population.

d. *Program Components*

The program for the autistic child will provide a structured, highly motivational, task-oriented behavior management system of educational intervention based on the following:

- a thorough understanding of the child in terms of developmental levels in the areas of learning readiness skills, academic skills, language skills, sensori-motor skills, self-help skills, independent living skills, and social and emotional development;
- selection of appropriate and realistic goals and related tasks in all areas based on an analysis of the child's emerging skills, an understanding of sequences of tasks for goals or skills, and the use of the child's relative strengths to work on weaknesses;

- anticipation of potential behavior management problems and recognition of deficits and other road blocks to effective teaching or learning, including the selection of appropriate tasks geared to the child's level of functioning, which reduces the likelihood of management difficulties;
- selection of appropriate motivational strategies for behavior change;
- selection of the most appropriate instructional materials and methods for each child.

Integral to the programming of the autistic child is the recognition that he/she is hindered by severe disturbances in developmental functions which prevent the child from establishing access to more normal family, social, educational, recreational, and vocational experiences. A program of special educational intervention related to specific needs in all areas of development should result in cognitive, emotional, and social growth, as well as educational achievement. Such progress should maximize the child's potential to relate to his/her family, peers, and relevant social institutions. Ultimately, the autistic child/youth should achieve self-actualization and employment within the realm of his/her capabilities.

e. *Program Coordination*

Special education and related services for the autistic child, both in the home and in structured classes, predicate the need for total program coordination through a systematic, interdisciplinary team approach in which all service providers working directly with the child contribute to the development and implementation of the IEP. Such individualization of programming sets the framework for student placement and the educational services to be provided.

Within the framework of the IEP, from the more restrictive environment, coordinative efforts will consist of:

- intensive and direct interdisciplinary and interagency team involvement, utilizing the services of medical, pyschological, physical, occupational, language, recreational, and parent training specialists, as well as specialists in other areas as required;
- interdisciplinary team involvement as a part of the total service delivery process, with primary program intervention provided by the teaching staff, parent trainer and direct service providers;
- limited integration into complementary special education situations beyond the autistic classroom, when appropriate;
- interdisciplinary team consultation with program intervention and responsibility shared by both autistic and other special education school staffs;
- placement in mainstream school situations, with partial special

education services and consultative support provided by the autistic program and/or special education school staff.

f. *Parent Involvement and Training*

The complexities and severity of the autistic syndromes mandate total intervention management for each child. The school curriculum and staff training programs are sophisticated and precise, yet the child may spend only a portion of his/her day in school. The remaining hours are spent with the parent. If there is to be success in educating this population, continuity, consistency, commitment, and communication between the school and home must exist. "Although ideal from the child's standpoint, absolute consistency between classroom and home is almost never attainable and to require this places unfair expectations on both teacher and parent. Rather, the home and the classroom may best be viewed as independent social systems in which the child operates. Common general goals should be established (e.g. appropriate behavior, self-sufficiency of habits). An open, direct relationship between classroom staff and parents should be developed and maintained. Techniques and strategies that work in one place may or may not be effective in the other for a variety of reasons, including the unpredictability of the child. Above all, respect for the needs and priorities of each environment is essential." (Division TEACCH, North Carolina, 1978.)

By law, the IEP of the child must be designed by the parent, school staff, and ancillary personnel. In this way, there is that all important carryover and exchange of home living, social, and academic skills into both environments. The parent acts to reinforce school activities and the school acts to reinforce the parent.

Active involvement of the parents might include their working with the child in a teaching situation at home or at school. The parents might implement a behavioral format in discipline or a reduction of a stereotropic behavior that has been targeted for extinction in the classroom. Whenever possible, the parents should be encouraged to participate in all social and recreational events occurring for their child. Daily or weekly communication between parent and school should be encouraged to enhance communication and problem solving between the home and school environments. Therefore, all programs for autistic children and youth should incorporate a comprehensive parent-training model which encourages the shared commitment and responsibility for the provision of a free and appropriate education.

2. *Mainstream Continuum of Services (With Multidisciplinary Support)—Regular Classes, Resource Rooms, Special Class Settings*

a. *Leadership*

Autistic programs established through the public school system should serve eligible students on a regional or statewide basis. Regional programming is necessary to ensure systematic and coordinated educational practices at the local level in the development of cost-effective and successful instructional models to meet the needs of this complex, low-incidence population.

b. *Program Coordination*

Appropriate educational programs for the autistic child, designed within less restrictive environments in the public schools, will generally require a self-contained special education situation. Aspects of student integration into "mainstream" school activities should be available according to the unique characteristics of each student. A total management approach will be necessary, including systematic program supervision and interdisciplinary team coordination.

In general, intervention guidelines for the autistic child on a less restrictive level are similar to the guidelines established for more restrictive settings. However, less restrictive program environments serve as controlled intermediate steps in the "mainstreaming" process. In this respect, less restrictive program environments allow for learning and living experiences with a more generalized school population and provide students with realistic opportunities to develop independent living skills and responsibilities.

SECTION V. STAFF PROFESSIONAL GROWTH

State and private education programs for autistic children are relatively rare and new. However, universities and medical schools are now concentrating their research on the etiology and diagnosis of the condition and on the development of the most effective instructional techniques for the intervention process. The involvement of professionals in continuing education is necessary if recent developments in research are to be incorporated into the educational plan for the autistic child. Therefore, a systematic framework for the on-going education of staff and parents is essential. Such inservice programming should renew and intensify the specific program commitments of the total staff, and it should provide mutual support to the parents.

Implementation of the program of continuing education for the professional staff will include aspects of the following training areas:

- General Education—
  - Video, slide, and lecture presentations for staff, ancillary personnel, university students, administrators, and medical professionals to develop expertise in the autistic syndromes and methods of teaching this special population (A demonstration classroom with one-way mirror is recommended for the professional development of new staff and university students, making it possible for them to observe teachers and other specialists working with the autistic children. This classroom could further be used for the critique of teaching staff by peer teachers and professional consultants.),
  - A coordinated statewide training program to provide special education teachers, educational diagnosticians, and psychologists with an understanding of the etiology, diagnosis, developmental milestones, and behaviors of the autistic syndromes,
  - A training program to develop in parents expertise in implementing a behavioral format in the home environment, to provide practical support for other parents of autistic children, and to develop within their number a cadre of autistic specialists and advocates;
- Inservice Staff Development—
  - Yearly participation in programs and training administered by experts in autism, including visitation by staff to recognized and exemplary autistic programs which could contribute to the development of Delaware's autistic program,
  - Opportunities for attendance at regional and national conferences on autism or services related to autism,
  - Statewide inservice training for staff members of autistic programs by expert consultants in autism (These meetings should include lectures and/or discussions on research and development of model cases, and practicum demonstrations of pertinent research issues, and presentations on related topics in child development, pediatric neurology, dental care, etc.);

- Administration and Management—
  - Provision for coordinated staff training on the part of all school districts participating in the educational intervention for autistic children,
  - Provision for local and statewide coordination of programs designed for the autistic child,
  - Development and administration of programs on county-wide basis;
- Related Services—
  - Development of a library of books, journals, literature, video tapes, and slides on the autistic syndromes and related information,
  - Establishment of a communication link for all literature, laws, and information relevant to autism published by the Federal government and the National Association for Autistic Children,
  - Coordination and cooperation of the autistic program with the University of Delaware to provide teaching and practicum experiences for their students and existing staffs, including academic equivalency credit for in-service and on-site training to be applied toward certification and graduate degrees,
  - Provision for consultation from resource persons and consultants in child development, psychology, speech, and related areas of development in autistic children.

SECTION VI. REFERENCES

An Educational Model for Autistic Children. A Guide for Developing a Public School Program, developed by Orange County School District, Florida, Volumes I, II, III, IV.

Cripe, Juliann J. *The Nature and Treatment of Autism.* A review of the Literature Department of Public Instruction, Des Moines, Iowa, 1978.

Donnellan-Walsh, Anne, Project Director. *Teaching Makes A Difference.* A Guide for Developing Successful Classes for Autistic and Other Severely Handicapped Children, Administrative Manual, Associates Publishing Service, 1976.

Kozloff, Martin. Reaching Autistic Children. A Parent Training Program, Research Press, 1973.

Marcus, Lee M., Louis P. Semrau, and Eric Schopler. *Division TEACCH:* Toward a Statewide Network of Public School Services for the Autistic Child and His Family. University of North Carolina, Chapel Hill, 1978.

Readings in Autism. Special Learning Corporation, Guilford, Connecticut, 1978.

Rimland, Bernard. *Infantile Autism.* Prentice Hall, Inc., Englewood Cliffs, New Jersey, 1964.

SECTION VII. GLOSSARY

attention. The ability to focus (attend) auditorily and/or visually to stimuli or input for a period of time without losing the context or content of that which is being presented.

attentioning skills. Those behaviors necessary for a child to successfully perform learning tasks, e.g., eye contact, appropriate sitting.

behavior. Anything an organism does which can be defined, observed and measured.

aversive stimulus. The presentation of an object contingent upon a response to decrease the frequency of an undesirable response.

disinhibition. Inability to control behavior as exemplified by the learner who gets carried away by his own thoughts and offers unrelated responses to that which is being discussed.

distractibility. Exhibiting "forced attention" to extraneous stimuli, resulting in poor overall attention and reduced on-task behavior.

echolalia. A language deficiency found in autistic people. An autistic person may echo or parrot words or phrases said to him.

expressive language. The ability to communicate by using words verbally, by writing, or by using gestures that describe or indicate a quality, a function, or a relationship.

extinction. The state in which a stimulus loses its power to bring about a response.

fine motor (eye-hand coordination). The purposeful coordinated movements of the hand and eye operating in concert with thought patterns to achieve a specific motor task, such as writing, sorting, and sewing.

generalization (stimulus generalization). The process of transferring a learned behavior within different but related stimulus environments.

gross motor. Movement that involves balance, coordination, and large muscle activity, as required for efficiency in walking, running, skipping, jumping, and other physical activities.

hyperactivity. An unusual amount of movement for a learner, considering his age and the physical setting in which the excessive movement is taking place.

interdisciplinary. Refers to the coordinated delivery of special education and related services in each case by teachers and specialists working together as a team in the development and implementation of the individualized education plan (IEP).

nonverbal language. The ability to assign meaning to gestures and expressions (body language) as well as to such cultural phenomena as art, music, holidays, or patriotism.

on-task behavior. Learner activity that is directed specifically toward the task as specified by the teacher and not extraneous to the task. For example, when the student is assigned the task of reading, he is doing more than just holding the book.

perseveration. The inability to use "stop and go" mechanisms efficiently; the learner will tend to repeat an act when it is no longer appropriate. He may have difficulty in shifting from one activity to another. For example, on tests he may repeat the previous response.

pronomial reversals. The inversion of "I" and "me" in the use of spoken language.

receptive language. The ability to apply meaning to words based on experience in terms of classification and association contingencies.

reinforcement. The presentation of a stimulus (reward) contingent upon a response to increase the frequency of a desired behavior.

self-abusive behaviors. Behaviors exhibited by some autistic people, such as excessive biting, hitting oneself, or banging one's head against a wall.

social perception. The ability to glean meaning from gestures and expressions or from what may appear to be easily discernible cause-effect relationships.

syntax. The ability to structure thought into grammatically correct verbal units or sentences.

time out. The removal of the opportunity to respond for reinforcement. Time out is presented contingently upon some response and is a form of punishment.

X

STATE OF DELAWARE
GENERAL GUIDELINES FOR THE DEVELOPMENT OF PROGRAMS OF SPECIAL EDUCATION AND RELATED SERVICES FOR CHILDREN AND YOUTH WITH MILD HANDICAPPING CONDITIONS
(Four to Six Years of Age)

The Delaware Department of Public Instruction

William B. Keene, *State Superintendent*
John J. Ryan, *Acting Deputy State Superintendent*
    Assistant State Superintendent
    Administrative Services Branch
Randall L. Broyles, *Assistant State Superintendent*
    Instructional Services Branch

X

STATE OF DELAWARE
GENERAL GUIDELINES FOR THE DEVELOPMENT OF PROGRAMS OF SPECIAL EDUCATION AND RELATED SERVICES FOR CHILDREN AND YOUTH WITH MILD HANDICAPPING CONDITIONS
(Four to Six Years of Age)

The Delaware Department of Public Instruction

William B. Keene, *State Superintendent*
John J. Ryan, *Acting Deputy State Superintendent*
Assistant State Superintendent
Administrative Services Branch
Randall L. Broyles, *Assistant State Superintendent*
Instructional Services Branch

The State of Delaware is an equal opportunity employer and does not discriminate or deny services on the basis of race, color, national origin, sex, handicap, and/or age.

Guideline Contributors:

Barbara E. Humphreys, State Specialist, Exceptional Children Programs, Diagnostician, Department of Public Instruction (Guideline Task Force Chairperson)

Peggy Bradley, Preschool Teacher, Area I, New Castle County School District

Mary V. Lauderbaugh, State Supervisor, Delaware Direction Service Center, Department of Public Instruction

Leroy Thompson, Director of Special Education, Area I, New Castle County School District

Sarah Van Camp, Ed.D., Professor, University of Delaware

Marjorie Van Gulick, Coordinator, Developmental Center, Delaware Curative Workshop, Inc.

DEFINTION:

Preschool children with mild handicapping conditions or developmental delays/disorders—Refers to children who will have reached their fourth birthday, but who shall not have reached their seventh birthday by December 31 of entry year; who show mild developmental handicapping conditions/disorders which may include, but not be restricted to, the areas of communication skills, motor skills, mental skills, and social/emotional skills, such that they are not maturationally ready to benefit from, or to participate in, the public school kindergarten or first grade program.

SECTION I. NATURE OF THE EXCEPTIONALITY

The term "developmental delays" refers to a wide variety of behaviors that are measurably below chronological age level in human growth and development.

The individual is a totality and it is impossible to isolate one area of functioning from another. In the assessment of a child, it is necessary to identify areas of deficit in his/her development, even though such deficits will overlap and interact. Mild delays (usually not more than 18 months below age level expectations) or deficits in any one or a combination of the following developmental areas shall be deemed sufficient for referral. The nature of each area of mild deficit is discussed briefly.

Mild communication delays/disorders

Language usually develops without perceivable effort or training with the majority of children. For some children, the natural flow of language appears to be interrupted by physical, emotional, or genetic interference. Such children will be delayed in the development of vocabulary, phrasing, and articulation, and they will manifest apparent confusions in auditory perception and comprehension.

Mild mental delays/disorders

Mental ability includes the processes of reasoning and the acquisition of concepts that are necessary for the perceptual and symbolic activities related to learning. Mental development is also related to the interaction of the child's genetic characteristics with his environment and the experiences in which he is involved. A child may exhibit a delay/disorder in development due to mental retardation, a developmental lag, or experiential deprivation.

Mild perceptual-motor delays/disorders

Motor skills, both fine and gross, usually develop without discernable effort or training. For the child with a mild delay/disorder, such movements may appear clumsy, immature, static, or poorly defined. Such children may have a poor concept of body/space relationships and may have difficulty in separating foreground/background stimuli in visual and auditory modalities. Tactile and kinesthetic responses may be exaggerated or reduced.

Mild social/emotional delays/disorders

Mild social/emotional delays/disorders may be apparent in early childhood, but are often not recognized until the child is of school age. Children whose basic behavioral functions (i.e., sleeping, eating, toileting, and social interaction) are significantly immature may fit this category. Other social/emotional problems may be manifested by hyperactivity, shyness, tantrums, excitability, overdependence and hostility. Great care should be taken not to hastily categorize a child as having a social/emotional disorder since these behaviors may be temporary or symptomatic of other underlying disorders.

Children with moderate and severe delays/disorders can best be served in programs for the specific handicapping conditions and, therefore, will not be treated in this section.

SECTION II. THE EDUCATIONAL CHALLENGE

Among children with mild developmental delays/disorders, the following types of educational problems may be observed:

Communication Skills

- difficulty in listening and following directions;
- immature speech, including poor articulation;
- limited vocabulary;
- poor language development;
- fragmented and unsequenced verbal expression;
- inattentive/inappropriate responses.

Mental Skills

- difficulty in organizing and using information;
- difficulty in making logical inferences;
- difficulty in anticipating consequences of behavior.

Perceptual Motor Skills

- falls frequently and drops things;
- immature jumping, skipping, hopping;
- inadequate body image;
- awkward in movement or action;
- poor spacial relationships;
- inability to sit or stand still for reasonable time for age;
- poor visual discrimination (not acuity);
- poor finger and hand dexterity;
- poor auditory discrimination;
- poor eye/hand coordination.

Social/Emotional Skills

- difficulty in relating to others;
- inappropriate behavior;
- behavioral extremes (withdrawn, overactive, distractable, perseverating);
- poor self-concept;
- poor emotional control (tantrums, etc.);
- difficulty in expressing emotions;
- difficulty in accepting help or guidance;
- overdependent on others;
- appears unaware of social/cultural values;
- poor self-help skills.

SECTION III. BASES FOR PLACEMENT

Rationale

Children who are screened and found to be candidates for a special preschool program should be placed in the least restrictive alternative in which they are able to function. Skilled referral, diagnosis, and prescriptive educational measures are essential to this process. It is assumed, therefore, that there will be adequate support services for the mildly handicapped child who is placed in the regular classroom. Early provision of such services should ensure that, with time, the child with a mild developmental delay/disorder will achieve his/her potential.

Conversely, the child who is found to have more serious developmental delays/disorders or a cluster of problems as outlined in Section II should be referred to a resource room or a self-contained classroom where specialized remediation programs will facilitate his/her return to the regular classroom.

A. *Specialized Interdisciplinary Systems—Statewide/Regional Special Schools and Facilities, Intensive Learning Centers, Institutional Settings*

Placement in a more restrictive alternative is warranted when the complexity and intensity of the developmental delay/disorder require a total closely coordinated day-to-day intervention by a specialized interdisciplinary team. On-going monitoring of the IEP and periodic formal assessment will provide assurance that appropriate programming is maintained for each child.

B. *Mainstream Continuum of Services (with Multidisciplinary Support)—Regular Classes, Resource Rooms, Special Class Settings*

Placement in a less restrictive alternative, such as a resource room program, would be appropriate for the child with mild developmental delays/disorders.

The issue in each case is whether the child's ability to cope allows for participation in, and profit from, the regular school program, provided that extra resource help is made available.

SECTION IV. THE DELIVERY OF SPECIAL EDUCATION AND RELATED SERVICES

A. *Identification and Diagnosis*

The identification process should include the use of recognized tests and procedures for screening:

- physical status;
- auditory and visual acuity;
- auditory, visual, and haptic perception;
- gross and fine motor functioning;
- language and communication skills;
- pre-academic skills;
- ability to relate socially/emotionally.

With respect to the processes of assessment and diagnosis, all observations and findings should be creative, sensitive, and formative in order to provide an accurate description of the unique nature of the developmental delay/disorder, including an analysis of present abilities.

B. *The Individualized Education Program (IEP)*

The development and implementation of the IEP for each child shall be the responsibility of the interdisciplinary IEP planning team appointed and supervised by the school administrators. The IEP which is developed must meet the standards and guidelines established in P.L. 94-142 and the *Administrative Manual for Programs for Exceptional Children*.

Because of the variances in developmental delays/disorders that manifest from child to child, it is essential that the specialized interdisciplinary IEP planning team coordinate all its observations and findings as a basis for the individualized education program.

C. *Staffing*

1. *Basic Considerations*

Personnel for programs that serve young handicapped children should be chosen with care, giving consideration to the following competencies and personal characteristics:

- knowledge of child development;
- ability to carry out child diagnosis of educational or social problems;
- skill in teaching young children;
- ability to communicate easily with children, parents and other staff;
- background knowledge of a wide range of handicaps;
- prior experience in working with young children;
- prior experience in working with handicapped children;

•

- adequate self-concept and confidence;
- knowledge of community agencies that serve young children.

When additional staff are to be hired for a program that will serve young handicapped children, every effort should be made to utilize staff that have dual certification. If this is not possible, the district should obtain a certified early childhood teacher if the majority of the children to be served are nonhandicapped. If the majority to be served are identified as handicapped, a special education teacher should be employed.

2. *Staffing Component of the Local District/Agency Plan*

The district should provide an assessment of the qualifications of professional and paraprofessional staff already employed by the district who may be working in the program. Where weaknesses exist in the qualifications, this component should outline the timeline and activities for assisting the staff in meeting full certification requirements (both early childhood and special education).

D. *Parent Involvement*

1. *Considerations*

Without the assistance of parents and family, the school staff will be unable to provide the level of intervention essential to the handicapped child's optimal habilitation and eventual placement in a regular educational program.

Federal and State regulations require the involvement of parents in the decision making process of educational or treatment intervention for their child. The parents should be an integral part of the intervention or educational program. To ensure effective participation at this level, many parents will need orientation, training, supportive counseling, or other services. Their needs may be as individual and varied as the special needs of their children. The individualized education program should specify activities to be carried out by parents, and it should provide the support system that will make it possible for them to participate fully in the intervention.

2. *Practical Aspects*

The district should outline the goals, objectives, activities, and evaluation of a program for the parents of the children who will be served. It is expected that such objectives may be few in number during the early stage of the program, but may expand as the program advances. The outline should include the projected time that staff can allot per week or month for parent involvement activities during each phase of program development and how opportunities may be provided for staff training or inservice related to parent education and counseling.

The plans for a parent program could include such activites as:

- shared parent and child learning experiences;

- demonstrations of learning activities for parents by staff;
- evening and weekend classes for parents;
- group discussions among parents;
- arranging parent visits to other programs where the child might be placed;
- inviting other agency experts to speak to parent groups;
- individual counseling for parents;
- providing learning packets that parents can use at home;
- providing educational prescriptions that parents can carry out at home;
- training parents to work as volunteers in the school;
- accompanying parents whose child is being "staffed" or evaluated by another agency;
- explaining to parents the specific target behaviors that will be the school focus during a specific time period.

E. *Program Structure*

1. *Specialized Interdisciplinary Systems—Statewide/Regional Special Schools and Facilities, Intensive Learning Centers, Institutional Settings*

a. *Leadership*

The building administrator and/or the special education coordinator for the district is usually responsible for the development and implementation of the program.

b. *Facility Spaces*

Each facility which houses programs for mildly developmentally delayed preschool children should include:

- instructional area(s);
- fenced outdoor learning area;
- attached bathroom with basins;
- sink for staff;
- facilities for large motor indoor activities;
- storage space for large motor equipment;
- "time out" area.

c. *Staff Composition*

(1) Certified teachers (Early Childhood-Special Education).

(2) Specific provision according to each child's IEP must be made for related services. Examples of related services include, but are not limited to, the following:

- occupational therapy;
- speech and language therapy;
- parent coordination;
- developmental movement education.

(3) Discretionary provision for social work, guidance, library administration, art and music instruction, school psychology, and physical education will be determined and recommended by the principal or coordinator in charge based on his/her analysis of the actual needs of the assigned pupil population.

d. *Program Components and Coordination*

It is assumed that a good preschool program will provide an environment for creativity and imagination, structure for discovery, opportunities for developing interpersonal relationships, play/learning experiences to foster basic cognitive development, and small group and individualized instruction to develop specific pre-academic skills.

In addition, special emphasis would be placed on sensory and perceptual activities (visual, auditory, haptic, olfactory, and gustatory), perceptual-motor training (fine and gross motor, eye/hand coordination, spacial relationships, and body image), language arts/communication skills (speech remediation, listening and following directions, opportunities for verbal expression), and self-help training (toileting, eating, dressing, etc.).

The instructional and therapeutic/remedial staff and parents must plan and work together as full team members in a unified interdisciplinary process to fully implement the above program. Research indicates that in order to maximize the progress of a preschool child, parents should be *actively* involved in the educational and therapeutic process. Therefore, a major component of this program must be parent training and an opportunity for parent participation as a full team member. To ensure the most effective management of the intervention, the classroom teacher should be designated as the program manager for each child.

2. *Mainstream Continuum of Services (with Multidisciplinary Support)—Regular Classes, Resource Rooms, Special Class Settings*

   a. *Leadership*

   The building administrator and/or the special education coordinator for the district shall be responsible for the development and implementation of the program.

   b. *Facility Spaces*

   The program would be carried out in a regular kindergarten or first grade classroom or a resource room.

   c. *Staff Composition*

   In addition to the regular kindergarten or first grade teacher and other specialists normally provided for the regular school population, provision for occupational therapists, speech and language specialist(s) and other related services will be determined by the child's individualized education program.

   d. *Program Components*

   The total program will be provided primarily within the regular kindergarten or first grade classroom or resource room with provision for related services as designated in the child's IEP. It is assumed that the classroom teacher will emphasize the four areas of growth enumerated earlier (communication skills, mental skills, perceptual motor skills and social/emotional development).

   e. *Program Coordination*

   The coordination of services should be the responsibility of the interdisciplinary team. As indicated, team members will include parent(s), the regular classroom teacher, preschool special education teacher, the person responsible for special education in the building, and any other individual providing special related services for the child.

Although it is recognized that the child may be absent from the regular classroom for periods of time to receive special services, the primary responsibility for the education of the child remains with the regular classroom teacher to whom the child is assigned.

F. *Interagency Coordination*

1. *Focus and Scope*

The largest child-serving agency in any community, the public schools, is the likely agency to serve as the coordinator of services to preschool age handicapped children. To fulfill this role, the schools must reach out to other agencies in the community or region in order to provide the full spectrum of services appropriate to the needs of each child. School districts cannot, and should not, expect to be able to deliver all services that young handicapped children will need. It is important, therefore, that staff become aware of all existing community resources and the procedures that guarantee their most effective utilization.

Cooperative referral and service arrangements with appropriate agencies and other community resources involved with preschool children include, but are not limited to, the following:

- public health and public health clinics;
- mental health clinics;
- hospitals;
- day care centers, nursery schools, and Headstart;
- physicians;
- local chapters of parent and lay associations, such as the Association for Retarded Citizens, United Cerebral Palsy, etc.;
- appropriate State agencies, such as the Division for the Visually Impaired, Division of Mental Retardation, and Division of Social Services;
- community service groups, such as Kiwanis, Lions Club, and church affiliated organizations.

Such knowledge of existing services can also assist parents in the location of supportive services for their handicapped child.

For their part, school personnel can assist other agencies to assess gaps in community services and intensify their services to children, parents, and the schools. In some cases, the school district may never offer direct services to the young handicapped child, but will be the major facilitator in seeing that the child receives the necessary services.

2. *Specific Aspects of Interagency Coordination at the Local Agency Level*

   a. The district should describe the strategies that will be used by the staff to learn about and use existing community resources for the young handicapped child. The activities may include:

      - building a library of materials that describe agency services for the use of staff and parents;
      - making visits to other agencies to learn about the services they offer;
      - developing a resource file with specific names and telephone numbers of agency personnel who will be contact persons for various services;
      - providing agencies in the community with a description of the school program, and its IPRD or referral process;
      - visiting community service groups to explain programs or to ask for assistance in building playground equipment, funding field trips, etc.;
      - training volunteer groups to work in the program.

   b. A description should be provided of the time that will be set aside for staff to become involved in interagency coordination. It is expected that the amount of time devoted to such activities will increase as the number of children in the program increases.

SECTION V. STAFF PROFESSIONAL GROWTH

Inservice training for professional persons working with mildly handicapped preschool children will be the responsibility of the local education agency and the State education agency. Staff should be provided the opportunity to attend in-state and out-of-state conferences and workshops which are pertinent to their professional responsibilities and interests and which will provide information on new curricula and techniques appropriate to their programs. Staff should be encouraged to pursue educational experiences which will enhance their classroom contributions, (e.g., graduate programs, out-of-state conferences and institutes, professional associations).

A. *Specialized Interdisciplinary Systems—Statewide/Regional Special Schools and Facilities, Intensive Learning Centers, Institutional Settings*

1. *General Program Orientation*

In each school building which houses a self-contained class of mildly handicapped preschool children, provision should be made annually for the total staff to become familiar with current pertinent Federal, State, and local regulations, policies, and priorities.

Similar provision should also be made for communication on the local level with the various program components of the special preschool program so that all personnel are aware of the total program and their relationship to it.

2. *Specific Program Implementation*

Provision should be made annually for the involvement of appropriate staff members in the review, modification, and renewal of the program for self-contained classrooms for mildly handicapped preschool children. Child study team interactions, essential to the effective implementation of the individualized education program for mildly handicapped preschoolers in self-contained classrooms, should be facilitated by the local education agency.

3. *Topical Presentations*

Staff who serve mildly handicapped preschool children should be provided the opportunity to attend inservice programs both locally and statewide.

Specific attention should be given to the following topics:

- Practical implementation of therapists' recommendations in classroom activities;
- Movement Education[1] Training for preschoolers;
- Sensory activities to enhance the five senses as basic learning tools for preschoolers;

---

[1] *Movement Education*— program based on the individualized teaching of movement according to the developmental level of each child (the English method).

- Perceptual/motor training along developmental guidelines;
- Utilization and interpretation of screening and diagnostic instruments for preschoolers;
- Presentation of a case report to a staff meeting;
- Development and implementation of the Individualized Education Program (IEP);
- Selection and/or development of curriculum (checklists, etc.) for preschoolers;
- Identification of available community resources for preschool programs;
- Training of aides to be more effective in the classrooms;
- Parent training for effective participation in the program;
- Development of awareness and sensitivity to bicultural/bilingual aspects of program implementation.

B. *Mainstream Continuum of Services (with Multidisciplinary Support) — Regular Classes, Resource Rooms, Special Class Settings*

1. *General Program Orientation*

To ensure that mainstreaming of mildly handicapped preschool children will be effective, there must be concise orientation and free exchange between the preschool special education teacher and the kindergarten teacher. Such an exchange will provide an adequate base for efficient implementation of the child's program.

2. *Specific Program Implementation*

Adequate provision must be made in every case for a thorough briefing to the general education staff concerning the individualized education program (IEP) of each child selected for this experience.

3. *Topical Professional Presentations*

In the mainstreaming process, it is essential that all staff members understand the needs of the handicapped and have respect for their abilities and achievements.

Inservice training should be held jointly with general education and special education teachers.

SECTION VI. REFERENCES

Ault, Ruth. *Children's Cognitive Development.* Oxford University Press, New York, 1977.

Cameron, W. and M. Cameron. *Education Movement in the Infant School.* Oxford: Basil, Blackwell and Mott, 1970.

Hare, Betty and James M. *Teaching Young Handicapped Children.* Grune and Stratton, New York, 1977.

Lillie, David L. *Early Childhood Education.* Science Resource Associates, Inc., Chicago, 1975.

Schwartz, Lita L. *The Exceptional Child.* Wadsworth Publishing Co., Inc., California, 1975.

Webb, Roger A., ed. *Social Development in Children.* Johns Hopkins Press, Baltimore, 1977.